(2)

No. 00-863

Supreme Court, U.S.
FILED
JAN 2 2001
CLERK

In The

Supreme Court of the United States

FRANKLIN J. DAY, M.D.,

Petitioner,

v.

SUPERIOR COURT, THE STATE OF CALIFORNIA, SAN FRANCISCO COUNTY,

Respondent,

DIVISION OF MEDICAL QUALITY OF THE MEDICAL BOARD OF CALIFORNIA,

Real Party in Interest.

On Petition For Writ Of Certiorari To The Court Of Appeal Of California For The First Appellate District

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

BILL LOCKYER
Attorney General
CARLOS RAMIREZ
Senior Assistant Attorney General
VIVIEN H. HERSH
Supervising Deputy Attorney General
ALFREDO TERRAZAS
Deputy Attorney General
Counsel of Record
1515 Clay Street, 20th Floor
Oakland, California 94612-1413
Telephone: (510) 622-2220
Fax No: (510) 622-2121
Counsel for Respondent

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

195 pp

QUESTION PRESENTED

California has in place a Medical Practice Act (California Business and Professions Code (§ 2000 et seq.)). The Medical Board of California, acting through its Division of Medical Quality Assurance, filed accusations against Petitioner herein alleging that he had violated the provisions of the Medical Practice Act. After a twenty-two day hearing before an impartial Administrative Law Judge, acting under California's Administrative Procedure Act (California Government Code § 11500 et seq.), petitioner's medical license was disciplined and he was placed on a five year probation with extensive terms and conditions. In California, a physician may challenge a decision of the Medical Board revoking, suspending, or restricting a license by filing a petition for administrative mandamus in the trial court. (California Code of Civil Procedure, § 1094.5) Petitioner filed a petition for administrative mandamus and did not prevail. Next, he filed a motion for a new trial and, again, did not prevail. Until a few years ago, either the physician or the Medical Board could seek review of a trial court's adverse decision by filing either an appeal or a petition for extraordinary relief before the California Court of Appeal. (See, e.g., *Franz v. Board of Medical Quality Assurance*, 31 Cal.3d 124, 181 Cal.Rptr. 732, 642 P.2d 792 (1982).) Effective January 1, 1996, however, the California Legislature amended Business and Professions Code § 2337 to provide for appellate review only by petition for extraordinary writ. The California Supreme Court has determined that § 2337 does not violate the appellate jurisdiction clause of the California Constitution. (See, e.g., *Leone v. Medical Board of*

QUESTION PRESENTED – Continued

California, 22 Cal.4th 660, 94 Cal.Rptr.2d 61, 995 P.2d 191 (2000).) (App. 78-106.) After the California Supreme Court issued its ruling in *Leone, supra*, it also ordered the re-publication of a California Appellate Court decision which had determined that § 2337 does not violate either the equal protection or due process protections of the California Constitution. (See, App. 208-259 to Petition, *Landau v. Medical Board of California*, 81 Cal.App.4th 191, 97 Cal. Rptr.2d 657 (1998) [Previously published at 60 Cal.App.4th 940, 71 Cal.Rptr.2d 54 (1998).] Against this background, the following questions are posed:

1. Does a trial judge who does not read every word of every page of a 22 day administrative transcript violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution in cases in which the court is authorized to exercise its independent judgment?

2. Does California Business and Professions Code § 2337, which limits appellate review of trial court decisions disciplining physician licensees to petitions for extraordinary relief, violate the Fourteenth Amendment to the United States Constitution?

3. Does the Medical Board of California have jurisdiction over one of its physician licensees, treating patients at both a Naval Hospital facility and his own two private practice offices, for violations of the California Medical Practice Act?

4. Was Petitioner herein disciplined for conduct not alleged against him?

LIST OF PARTIES

Real Party in Interest, Medical Board of California, accepts petitioner Dr. Day's version of the List of Parties as stated in his Petition for Writ of Certiorari.

TABLE OF CONTENTS

Page

QUESTION PRESENTED..... i

LIST OF PARTIES..... iii

TABLE OF AUTHORITIES..... vi

REAL PARTY IN INTEREST'S BRIEF IN OPPOSITION..... 1

OPINIONS BELOW..... 1

STATEMENT OF JURISDICTION..... 1

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED..... 1

STATEMENT OF THE CASE..... 2

REASONS FOR DENYING THE PETITION..... 11

I. THE ISSUE PRESENTED TO THIS COURT LACKS THE SUFFICIENT NATIONAL IMPORTANCE TO WARRANT A GRANT OF CERTIORARI..... 12

II. ALTHOUGH NO EVIDENCE EXISTS THAT THE TRIAL COURT FAILED TO CONSIDER ALL EVIDENCE CITED TO IT BY PETITIONER BY THE TIME OF THE HEARING ON THE MOTION FOR A NEW TRIAL, ASSUMING *ARGUENDO* THAT IT DID, CASE LAW DOES NOT REQUIRE THE TRIAL COURT TO READ EVERY LINE OF EVERY PAGE OF THE ADMINISTRATIVE RECORD IN ORDER FOR IT TO EXERCISE ITS INDEPENDENT JUDGMENT..... 20

TABLE OF CONTENTS – Continued

Page

III. PETITIONER'S RELIANCE ON *SOLORIO* IS MISPLACED AND DOES NOT AFFECT REAL PARTY IN INTEREST'S JURISDICTION OVER HIS MEDICAL PRACTICE 23

IV. PETITIONER WAS NOT DISCIPLINED FOR MATTERS NOT ALLEGED IN WRITING 26

CONCLUSION 28

TABLE OF AUTHORITIES

Page

CASES

Allyn Beth Landau, M.D. v. Medical Board of California, (re-published) 81 Cal.App.4th 191, 97 Cal.Rptr.2d 657 (1998) 8, 10

Bixby v. Pierno, 4 Cal.3d 130, 93 Cal.Rptr. 317 (1971) 21

Cleveland Chiropractic College v. State Bd. of Chiropractic Examiners, 11 Cal.App.3d 25, 89 Cal.Rptr. 572 (1970) 19

Dare v. Board of Medical Examiners, 21 Cal.2d 7 (1943) 21

Drummey v. State Bd. of Funeral Directors, 13 Cal.2d 75, 87 P.2d 848 (1939) 20, 21

Ettinger v. Board of Medical Quality Assurance, 135 Cal.App.3d 853, 185 Cal.Rptr. 601 (1982) 17

Guymon v. Board of Accountacy, 55 Cal.App.3d 1010 (1976) 21

Hudson v. Louisiana, 450 U.S. 40 (1981) 12

In re Ruffalo, 390 U.S. 544, 20 L.Ed.2d 117 (1968) 26

Katzinger v. Chicago Metallic Mfg. Co., 329 U.S. 394 (1947) 12

Kenneally v. Medical Board, 27 Cal.App.4th 489, 32 Cal.Rptr.2d 504 (1994) 14, 15, 16

Lacy v. California Unemployment Ins. Appeals Bd., 17 Cal.App.3d 1128, 95 Cal.Rptr. 566 (1971) 19

Landau v. Superior Court, (formerly) 60 Cal.App.4th 947, 71 Ca.Rptr.2d 54 (1998), review granted April 15, 1998 (S068095) 10, 13, 14, 16

Leone v. Medical Board, (formerly) 57 Cal.App.4th 1240, 67 Cal.Rptr.2d 689 (1997) 13

TABLE OF AUTHORITIES – Continued

Page

Leone v. Superior Court, 22 Cal.2d 660, 94 Cal.Rptr.2d 61 (2000) 1, 10

Los Alamitos General Hospital, Inc. v. Director of Dept. of Health, 86 Cal.App.3d 417, 149 Cal.Rptr. 98 (1978) 19

MacGregor v. Westinghouse Co., 329 U.S. 402 (1947) 12

Massachusetts Board of Retirement v. Murgia, 427 U.S. 307 (1976) 16

Moran v. Board of Medical Examiners, 32 Cal.2d 301 (1948) 21

O'Callahan v. Parker, 395 U.S 258, 89 S. Ct. 1683, 23 L.Ed.2d 291 (1969) 23

People ex rel. Younger v. County of El Dorado, 5 Cal.3d 480, 96 Cal.Rptr. 553, 487 P.2d 1183 (1971) 15

Pittsburgh v. Alco Parking Corp., 417 U.S. 369 (1974) 12

Rittenband v. Cory, 159 Cal.App.3d 410, 205 Cal.Rptr. 576 (1984) 15

Smith v. Board of Medical Quality Assurance, 202 Cal.App.3d 316, 248 Cal.Rptr. 704 (1988) 15

Solorio v. United States, 483 U.S 435, 107 S. Ct. 2924, 97 L.Ed.2d 364 (1987) 23, 25

William E. Arnold Co. v. Carpenters District Council, 417 U.S. 12 (1974) 12

Woods v. Holy Cross Hospital, 591 F.2d 1164 (5th Cir. 1979) 16

Yellen v. Board of Medical Quality Assurance, 174 Ca.App.3d 1040, 220 Cal.Rptr. 426 (1985) 17

TABLE OF AUTHORITIES – Continued

Page

CONSTITUTIONS

Cal. Const., art. I, § 7 ..... 14, 15

U.S. Const., 14th Amend. 14, 15, 17

STATUTES AND RULES

Bus. & Prof. Code § 2337 ..... *passim*

Bus. & Prof. Code §§ 6082, 6083 18

Bus. & Prof. Code §§ 23090-23090.5 18

Cal. Rules of Court, Rule 29.2(c) 9

Cal. Rules of Court, Rule 977(a) 13

California Gov't Code §§ 3520, 3542, and 3564 18

California Gov't Code § 11503 27

California Gov't Code § 11511 15

Fed.R.Civ.P.63 1

Labor Code §§ 5950-5955 18

Labor Code § 1160.8 18

Public Util. Code, §§ 1756, 1759 18

REAL PARTY IN INTEREST'S BRIEF IN OPPOSITION

Real Party in Interest, the Division of Medical Quality of the Medical Board of California ("Board") respectfully requests that this Court deny the Petition for Writ of Certiorari ("Petition") of Franklin J. Day, M.D. ("Petitioner").

OPINIONS BELOW

The Board accepts petitioner's statement of the Opinions Below as contained in his Petition and as reproduced in petitioner's Appendix. An additional relevant court case is contained and reproduced in the Board's Opposition, *Leone v. Superior Court*, 22 Cal.2d 660, 94 Cal.Rptr.2d 61 (2000).

STATEMENT OF JURISDICTION

The Board accepts petitioner's Statement of Jurisdiction as contained in his petition.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

With the exception of Fed.R.Civ.P. 63, which is not applicable, the Board accepts petitioner's statement of the Constitutional and Statutory Provisions Involved as contained in his Petition and as reproduced at App. 202-205 of the Petition.

STATEMENT OF THE CASE

Petitioner's California physician and surgeon certificate was issued to him by the Board on May 18, 1979. (App. 110 to the Petition.)

From January 1984 through December 1984 he was head of the Anesthesiology Division, Department of Surgery, Naval Hospital, Corpus Christi, Texas. From December 1984 through December 1990, he worked as an anesthesiologist with a non-military hospital, Los Medanos Hospital, Pittsburg, California. Over that same period, he founded and was medical director of the Pain Relief Center, with offices in Walnut Creek and San Leandro, California.

The initial source of information which began the first investigation of petitioner's practice was a legally mandated Business and Professions Code § 801 (b) Report of Settlement, Judgment or Arbitration Award from petitioner's own Professional Liability Insurance Carrier filed on May 18, 1990. (Appendix Exh. "GG" to Petition, Admin. Exh. 5).[1] Thereafter, multiple investigations were opened, on a "piecemeal basis," as the Medical Board of California became aware of other lawsuits, settlements and complaints against petitioner. (Admin. Exh. 33, 47, 57, 73.)

---

[1] References to the Appendix to the Petition for Mandamus, filed in the California First District Court of Appeal, Case No. A080131, specifically Exh. "GG" to the petition, the Administrative Exhibits, shall hereafter be referred to as "Admin. Exh. ___." During the administrative hearing below, Real Party in Interest's exhibits were assigned a numerical designation; e.g., 1-108, and Petitioner's exhibits were assigned a letter designation; e.g., A-JJ.

On February 2, 1994, Real Party in Interest, the Board filed an Accusation against petitioner, an anesthesiologist by training who practiced pain management medicine, alleging two causes for disciplinary action regarding a single patient, M.O.[2] (App. 14-20.)

This patient was treated by petitioner in his private practice Pain Relief Center located in Walnut Creek, California, not on a military facility. (Appendix Exh. "GG" to Petition, Admin. Exhibits 5 and JJ). The Administrative Law Judge's (hereinafter "ALJ") Findings of Fact and Determinations of Issues[3] found that in regard to her care and treatment, petitioner in a grossly negligent and incompetent manner encouraged and allowed the patient to self-inject morphine through an epidural (through the lower back and into the spinal fluid) catheter. (App. 132 to the Petition.)

On February 16, 1995, Real Party in Interest filed a First Supplemental Accusation against petitioner, involving three other patients, alleging similar conduct as

---

[2] Initials were used to identify the patients in the accusatory pleadings and although un-redacted medical records and expert reports were introduced into evidence during the administrative hearing, both the ALJ's and trial court's decisions refer to the patients by initials. (App. 20-101, 109-201 to the Petition.)

[3] The Findings of Fact and Determination of Issues made by the ALJ set forth in the Statement of the Case hereinabove were determined to be supported by the weight of the evidence upon review by the trial court in exercising its independent judgment of the record. (App. 21 to the Petition.) Additionally, the trial court also found that the ALJ applied the correct standard of proof, clear and convincing evidence to a reasonable certainty, in reaching his decision. (App. 92 to the Petition.)

described hereinabove. The three patients were M.G., M.H. and B.C. (App. 23-45.)

During the period that petitioner served as the Director of the Pain Clinic at Oak Knoll Naval Hospital in Oakland, he and his staff provided medical care and treatment for patient M.G. This is the only one of the six patients alleged in the accusations filed by the Board against petitioner who was treated exclusively at a military hospital. The ALJ's findings of fact and determinations of issues found that in regard to his care and treatment, petitioner was negligent in failing to develop and record a specific treatment plan. (App. 139, 192 to the Petition.)

Petitioner first saw patient M.H., upon referral, on January 29, 1993. (App. 47 to the Petition.) Petitioner saw the patient at his private practice Pain Relief Center in San Leandro, California. (Admin. Exh. 50.) The ALJ's findings of fact and determinations of issues found that in regard to his care and treatment, petitioner was negligent in giving methadone on a prn (as needed) basis to a patient with a known history of addiction to cocaine and street drug abuse and known history of suicide attempts. (App. 148-149 to the Petition.)

Patient B.C. was a 37 year old man with a history of cat scratch fever, resulting in the removal of cysts on the left side of his neck. Kaiser Hospital in Vallejo, California referred him to petitioner. (App. 151 to the Petition, Admin. Exh. 63.) Petitioner saw the patient in his private practice Pain Care Center in Walnut Creek, California. (Appendix Exh. "FF", Admin. Hearing Transcript, Vol. I,

24:3-6, 25:14-17).[4] As a result of petitioner's treatment, patient B.C. suffered catastrophic complications. (App. 154 to the Petition.) The ALJ's findings of fact and determinations of issues found that in regard to his care and treatment of patient B.C., petitioner's care represented both an extreme departure from the standard of care (gross negligence) and a lack of knowledge and ability in carrying out his professional medical obligations (incompetence). (App. 160 to the Petition.)

On October 13, 1995, a Second Supplemental Accusation was filed against petitioner, involving two final patients, J.W. and A.C. (App. 48-77.)

On August 28, 1986, petitioner first saw patient J.W. He examined and treated her in his private practice Pain Relief Center in Walnut Creek, California. (App. 161 to the Petition, Admin. Exh. 74, "FF".) The ALJ's findings of fact and determinations of issues found that in regard to his care and treatment of patient J.W., petitioner was grossly negligent in allowing the patient to self inject narcotics via an intrathecal (subarachnoid) catheter. (App. 168-169 to the Petition.)

The final patient alleged in the accusations filed against petitioner was A.C. Petitioner first saw patient A.C. on November 30, 1987. (App. 173 to the Petition.) Petitioner treated her in his private practice Pain Relief

---

[4] References to the Reporter's Transcript of the Administrative Hearings, Appendix Exh. "FF" to the Petition for Mandamus, filed in the California First District Court of Appeal, Case No. A080131, shall hereafter be referred to by their individual volume numbers, using their original Roman Numeral designation; e.g., Vol. I.

Center in Walnut Creek, California. (Admin. Exh. 86.) During the course of her treatment by petitioner, after she received several morphine injections via catheter, and epidural technique, A.C. passed out in her office parking lot and was taken by strangers to John Muir Medical Center, a non-military facility, where she was hospitalized. (App. 176 to the Petition.) When next he tried to inject morphine, epidurally, her 14 year old son was given some Narcan (a narcotic antagonist) in a syringe in the event she had a problem. (App. 177 to the Petition.) The ALJ's findings of fact and determinations of issues found that in regard to his care and treatment of patient A.C., petitioner was grossly negligent in allowing the patient to self inject narcotics via epidural and intrathecal catheters. (App. 185-186 to the Petition.) In addition, petitioner was also found to have been grossly negligent in allowing and teaching the patient's minor 14 year old son in injecting the narcotic antagonist, Narcan. (App. 187-188 to the Petition.)

The twenty-two day administrative hearing was held beginning January 2, 1996 and continuing through February 7, 1996. (App. 109 to the Petition.)

On August 9, 1996, the Medical Board issued its Decision, effective September 9, 1996, adopting the Proposed Decision of ALJ Jonathan Lew. (App. 108 to the Petition.)

Petitioner filed a timely Petition for Writ of Administrative Mandamus before the trial court. (Appendix Exh. "A".)

On February 6, 1997, the parties appeared before the trial court to argue the Writ. Earlier that same day the Court had posted its tentative ruling denying the Writ.

However, after hearing the arguments, the trial court decided to take the matter under submission while it further reviewed the administrative record. (Appendix Exh. "E".)

On February 10, 1997, the trial court signed its Order Denying Peremptory Writ and discharged the stay. (Appendix Exh. "F".) After the Board submitted its proposed Statement of Decision, as ordered by the trial court, and objections were filed by petitioner herein, a 56 page Statement of Decision was signed by The Honorable Judge William Cahill of the Superior Court on June 16, 1997. (Appendix Exh. "I".)

On July 17, 1997, petitioner filed a Motion for a New Trial. (Appendix Exh. "K", "L" and "M".)

On July 29, 1997, the Board filed its Opposition to a New Trial and for Order Setting Aside Judgment. (Appendix Exh. "O", "P", "Q" and "R".)

On August 12, 1997, the parties appeared and argued the matter before Judge Cahill in the San Francisco Superior Court. Once oral argument began, Judge Cahill advised counsel for the petitioner that, in fact, he had not read every word of every one of the administrative transcripts but that he had looked at all of the cites in the brief. (App. 3-4, fn. 1 to the Petition, Appendix Exh. "U", Reporter's Transcript of Proceedings, August 12, 1997, 3:22-4:2.)

That same day, August 12, 1997, the trial court denied petitioner's Motion for a New Trial. (Appendix Exh. "V" and "W".)

On September 25, 1997, Dr. Day filed a Petition for Extraordinary Writ with California's First Appellate District Court of Appeal with a Request for an Immediate Stay.

On October 1, 1997 the Court of Appeal denied the Stay.

On October 6, 1997, on behalf of the Real Party in Interest, the Board filed a Preliminary Opposition to the Petition.

On November 7, 1997, Petitioner filed a Preliminary Reply in Support of the Petition for Writ of Mandate.

On January 12, 1998, California's First Appellate District Court of Appeal issued its decision in a related matter, certified for publication, in *Allyn Beth Landau, M.D. v. Medical Board of California,* (re-published) 81 Cal.App.4th 191, 97 Cal.Rptr.2d 657 (1998). (App. 208-259 of the Petition.) The *Landau* decision ruled on many of the same issues raised by Dr. Day in his petition challenging the constitutionality of Business and Professions Code § 2337; e.g. whether it violated the Equal Protection and Due Process Clauses of the California and U.S. Constitution. The Court in *Landau* found § 2337 to be constitutional.

On January 8, 1999, having almost a full year earlier issued its ruling in the *Landau* case on the constitutionality of § 2337, the First District Court of Appeal wrote to Real Party in Interest requesting supplemental points and authorities on the issue of whether the trial court below had sufficiently reviewed the evidence from the administrative disciplinary proceeding to satisfy the

independent judgment review required of the trial court in such matters.

On January 25, 1999, Real Party in Interest filed its Supplemental Points and Authorities pointing out that the trial judge understood his duty to exercise his independent judgment in making his decision and that he did just that by carefully reviewing all the cites to the administrative record called to his attention by the parties.

On March 30, 1999, the First District Court of Appeal issued in ruling denying Petitioner's Writ Petition by way of an unpublished 8 page ruling. (App. 1-8 of the Petition.) The Court indicated that the key to their decision was the distinction between "reading" and "reviewing" the administrative record noting that in order to "review the entire record" it was not strictly necessary to read every word, as long as the petitioner had directed the attention of the court to those material portions of the record he or she contended undermine the administrative decision. (App. 7-8 to the Petition.)

On April 12, 1999, Petitioner filed a Petition for Review in the California Supreme Court.

On April 14, 1999, Real Party in Interest wrote to the First District Court of Appeal requesting publication of the decision.

On April 15, 1999, the First District Court of Appeal wrote to the California Supreme Court recommending against the publication of its decision.

On April 28, 1999, the California Supreme Court granted the Petition for Review with further action deferred pending consideration and disposition of a related issue in *Leone v. Medical Board*, S065485 (Cal. Rules

of Court, Rule 29.2(c)), or pending further order of the court. (App. 11 to the Petition.)

On April 3, 2000, the California Supreme Court upheld the constitutionality of § 2337 in *Leone v. Medical Board*, 22 Cal.4th 660, 94 Cal.Rptr.2d 61, 67, 995 P.2d 191 (Cal. 2000). (App. 78-106.)

On June 14, 2000, the California Supreme Court dismissed review in this case, the same day that the California Supreme Court dismissed review in *Landau*[5] and directed publication of the First District's opinion in the *Landau* case. (App. 206-207 to the Petition.)

On July 5, 2000, Petitioner filed with the First District Court of Appeal a Motion to Stay Issuance of Remittitur in Order to Permit Petitioner to Petition the U.S. Supreme Court for a Writ of Certiorari.

On July 19, 2000, Petitioner's Motion to Stay Issuance of Remittitur was granted in such a manner that the stay would automatically dissolve on November 13, 2000 at which time the clerk of the court would issue the Remittitur.

On August 9, 2000, the Second District Court of Appeal, upon remand from the California Supreme Court, issued its Order in *Leone*, agreeing with the First Appellate District's decision in the *Landau* case that

---

[5] *Landau v. Superior Court*, S068095, was dismissed and remanded to the Court of Appeal. The opinion of the Court of Appeal, originally printed at 60 Cal.App.4th 940 (1998) was ordered republished and appears at 81 Cal.App.4th 191. Publication page references are not yet available for this decision, although it does appear in the advance sheets, California Official Reports, Number 18, July 4, 2000.

§ 2337 does not violate equal protection and due process considerations. (App. 109-110.)

On November 17, 2000, the First District Court of Appeal issued its Remittitur, certifying that the decision in Petitioner's matter entered on March 30, 1999 had become final. (App. 112-113.)

On November 20, 2000, Petitioner wrote to the First District Court of Appeal asking that it recall or stay the Remittitur issued on November 17, 2000. (App. 114-115.)

On November 20, 2000, Real Party in Interest once again wrote to the First District Court of Appeal requesting publication of the decision.

On December 5, 2000, the First District Court of Appeal once again wrote to the California Supreme Court recommending against the publication of its decision.

On December 8, 2000, the First District Court of Appeal wrote to Petitioner advising that it had no authority to grant his request because the decision has become final. (App. 118-119.)

REASONS FOR DENYING THE PETITION

Petitioner fails to state a compelling case that the constitutionality of Cal. Bus. & Prof. Code § 2337 is of such national urgency as to warrant review by this Court and the Court should deny review.

The California Court of Appeal's unpublished decision in this matter (App. 1-8 to the Petition) carries no precedential weight beyond the limits of this case. As

such, the questions of law presented here, already judicially resolved twice by the First District Court of Appeal of California, as well as the California Supreme Court in favor of the Board, lack sufficient national importance to warrant a third appellate review by this Court.

In summary, here the California Court of Appeals, supported by the California Supreme Court, has decided [in *Landau*] that a state statute [the same statute in question here, § 2337] is constitutional as against an equal protection and due process challenge under both the California State Constitution and by an analysis consistent with challenges alleging similar violations of the U.S. Constitution, that it is not in violation of the U.S. Constitution. Petitioner has failed to demonstrate that a conflict between decisions of a highest state court and a federal court of appeals on a matter of federal law exists; *Katzinger v. Chicago Metallic Mfg. Co.*, 329 U.S. 394 (1947); *MacGregor v. Westinghouse Co.*, 329 U.S. 402 (1947). Similarly, Petitioner has failed to demonstrate that a conflict between decisions of a highest state court and that of the U.S. Supreme Court on a matter of federal law exists; *Hudson v. Louisiana*, 450 U.S. 40, 42 (1981); *William E. Arnold Co. v. Carpenters District Council*, 417 U.S. 12, 14 (1974); *Pittsburgh v. Alco Parking Corp.*, 417 U.S. 369, 371-72 (1974).

I. THE ISSUE PRESENTED TO THIS COURT LACKS THE SUFFICIENT NATIONAL IMPORTANCE TO WARRANT A GRANT OF CERTIORARI

Petitioner overstates both the significance and potential ramifications of the Court of Appeal's decision for physicians in California and in other states of the Union.

Publication of the decision was denied, twice, by the Court of Appeal and is not a part of the official case reports of California. As such, under California law, the decision cannot "be cited or relied on by a court of a party in any other action or proceeding." (Cal. Rules of Court, Rule 977(a).) Any potential impact attending to the decision as controlling legal authority thus does not extend beyond the limits of this case.

During the pendency of petitioner's case in the California judicial system, a disagreement arose in the Courts of Appeal on the constitutionality of section 2337. In *Leone v. Medical Board*, (formerly) 57 Cal.App.4th 1240, 67 Cal.Rptr.2d 689 (1997), review granted December 23, 1997 (S065485), Division Four of the Second District held that the statute was an impermissible attempt to interfere with the constitutional jurisdiction of the Courts of Appeal as defined in article VI, section 11 of the California Constitution. In *Landau v. Superior Court*, (formerly) 60 Cal.App.4th 940, 71 Cal.Rptr.2d 54 (1998), review granted April 15, 1998 (S068095), Division Two of the First Appellate District held that the statute did not violate article VI, section 11 and that the section does not deny a physician either equal protection or due process.

On April 3, 2000, the California Supreme Court issued its decision in *Leone, supra*, finding that the argument that section 2337 substantially impairs the exercise of appellate jurisdiction was not persuasive and that "by common understanding, a reviewing court may exercise this power in the procedural context of a direct appeal or a writ petition." (App. 83.)

After ruling in the *Leone* case, the California Supreme Court then went on to issue its Order, on June 14, 2000,

En Banc, in the *Landau* case. (App. 206 to the Petition.) The court directed the Reporter of Decisions to partially publish the opinion in the *Landau* case in accord with the Court of Appeal's prior partial publication of the opinion at 60 Cal.App.4th 940.

In the re-published *Landau* decision, the California Court of Appeal indicated that in its analysis of the equal protection claim, "The Fourteenth Amendment's guarantee of equal protection and the California Constitution's protection of the same right (Cal. Const., art. I, § 7, subd. (a), art. IV, § 16, subd. (a) are substantially equivalent and are analyzed in a similar fashion. [Citations.]" *Kenneally v. Medical Board*, 27 Cal.App.4th 489, 495, 32 Cal.Rptr.2d 504 (1994) (App. 230 to the Petition.)

The court then went on to find that section 2337 did not violate equal protection or due process considerations and reversed the judgment of the trial court.

While the constitutionality of any state statute is an important issue to California, the Court of Appeal's decision in *Landau* resolved the questions of whether Bus. & Prof. Code § 2337 violates the equal protection and due process clauses of both the California and U.S. Constitution in a manner fully consistent with existing constitutional jurisprudence. This is reflected in the Court of Appeal's language in *Landau*, where it stated:

> "[T]he equal protection clause requires that those similarly situated not be treated differently unless the disparity is justified." (*Board of Supervisors v. Local Agency Formation Com.*, 3 Cal.4th 903, 914, 13 Cal.Rptr.2d 245 (1992); *Kenneally v. Medical Board*, 27 Cal.App.4th 489, 495, 32 Cal.Rptr.2d 504 (1994).) "The Fourteenth Amendment's guarantee of equal protection and

> the California Constitution's protection of the same right (Cal. Const., art. I, § 7, subd. (a), art. IV, § 16, subd. (a)) are substantially equivalent and are analyzed in a similar fashion. [Citations.]" *Kenneally, supra,* at p. 495. *Landau, supra,* 81 Cal.App.4th 191, 207.

It is clear that California cases have long held that equal protection analysis of the provisions of the state constitution are substantially equivalent to the analysis of the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution. *People ex rel. Younger v. County of El Dorado,* 5 Cal.3d 480, 502, fn. 23, 96 Cal.Rptr. 553, 487 P.2d 1183 (1971); *Rittenband v. Cory,* 159 Cal.App.3d 410, 417, 205 Cal.Rptr. 576 (1984), citing *Dunn v. Blumstein,* 405 U.S. 330, 335, 92 S.Ct. 995 (1972).

This "rational basis" analysis has also been recognized and applied in previous equal protection and due process challenges to California Medical Practice Act provisions. *Smith v. Board of Medical Quality Assurance,* 202 Cal.App.3d 316, 324, 248 Cal.Rptr. 704 (1988).

As in the *Landau* case, *Kenneally, supra,* 27 Cal.App.4th 489 is dispositive of Dr. Day's claim that he has a fundamental right to continue to practice his licensed profession. In *Kenneally,* a physician contended that Government Code section 11511 denied him equal protection (U.S. Const., 14th Amend.; Cal. Const., art. I, § 7) by restricting prehearing depositions in physician disciplinary proceedings. The Court of Appeal refused to utilize strict scrutiny review and held the rational basis test was the standard of review applicable to the doctor's claim.

The *Landau* court went on to conclude that in California a physician's right to continue to practice a licensed profession is not a fundamental right for equal protection purposes and, accordingly, in evaluating whether § 2337 denied her equal protection, the rational basis test applied. (App. 235 to the Petition.)

The reasoning employed by California's First District Court of Appeal in *Landau* thus is wholly consistent with *Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 313, 49 L.Ed.2d 520, 524-525, 96 S.Ct. 2562 (1976)[6]

> "We need only state briefly our reasons for agreeing that strict scrutiny is not the proper test for determining whether the mandatory retirement provision [age 50 for state police officers] denies appellee equal protection. *San Antonio School District v. Rodriguez*, 411 U.S. 1, 16, 93 S.Ct. 1278, 1287, 36 L.Ed.2d 16 (1973), reaffirmed that equal protection analysis requires strict scrutiny of a legislative classification only when the classification impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class . . .

---

[6] In some situations, the United States Supreme Court has applied an "intermediate standard" of review that is not as difficult for the government to meet as the compelling interest test, but which involves far less deference to the legislature than does the rationality test. Under the intermediate standard of review, the justices will not uphold a classification unless they find that the classification has a "substantial relationship" to an "important" government interest. The United States Supreme Court has used this intermediate standard of review in cases involving gender classifications and cases involving illegitimacy classification. *Woods v. Holy Cross Hospital*, 591 F.2d 1164, 1172-1173 (5th Cir. 1979). *Kenneally, supra*, at p. 495, fn. 4.)

> "Nor does the class of uniformed state police officers over 50 constitute a suspect class for purposes of equal protection analysis. *Rodriguez, supra,* 411 U.S. at 28, 93 S.Ct. at 1294., observed that a suspect class is one 'saddled with such disabilities, or subjected to such a history of purposeful unequal treatment, or relegated to such a position of political process.' " *Massachusetts, supra,* 427 U.S. at 312-313, 96 S.Ct. at 2566-2567.

Thus, Petitioner's contention that § 2337 is unconstitutional on the grounds that it violated the Due Process Clause, Commerce Clause and Equal Protection Clause of the United States Constitution is not persuasive. Limiting appellate scrutiny of superior court decisions in physician discipline cases to review by extraordinary writ is rationally related to the governmental purpose of reducing delay in such cases.

Today, before such a case reaches the California Court of Appeal, two separate written decisions exist detailing all the findings of fact and determination of issues. Further, the standard of review applied in each decision is very high; clear and convincing proof to a reasonable certainty that discipline is warranted at the administrative level (*Ettinger v. Board of Medical Quality Assurance,* 135 Cal.App.3d 853, 856, 185 Cal.Rptr. 601 (1982), and a *limited trial de novo,* where the superior court exercises its independent judgment to determine whether the Board's findings are supported by the weight of the evidence, based on the administrative record. (*Ettinger, supra,* 135 Cal.App.3d at 858; *Yellen* v. *Board of Medical Quality Assurance,* 174 Cal.App.3d 1040, 1057, 220 Cal.Rptr. 426 (1985).)

Nothing in section 2337, as amended and effective January 1, 1996, has changed this.

Petitioner's suggestion that writ review for physician discipline cases necessarily constitutes an inadequate review sidesteps the numerous instances in which writ review is the only avenue for review of an administrative case. For example, judicial review of decisions of the Public Utilities Commission is via petition for certiorari in the California Supreme Court (Public Util. Code, §§ 1756, 1759); judicial review of attorney discipline cases is by petition for review to the California Supreme Court or the California Court of Appeal (Bus. & Prof. Code §§ 6082, 6083); judicial review of Workers' Compensation Appeals Board decisions is via petition for writ of review in the California Supreme Court or the Court of Appeal (Labor Code §§ 5950-5955); judicial review of Alcoholic Beverage Control Appeals Board decisions is via writ of review in the California Supreme Court or the Court of Appeal (Bus. & Prof. Code §§ 23090-23090.5); judicial review of Agricultural Labor Relations Board decisions is by petition to the Court of Appeal (Labor Code § 1160.8); and judicial review of Public Employee Relations Board unit determinations and unfair practice cases can be obtained only by petition for extraordinary writ to the Court of Appeal. (California Gov't Code §§ 3520, 3542, and 3564.)

As earlier noted, the trial court upheld the findings upon which the Board ultimately based its decision to discipline Petitioner's license. Since the record shows that the trial court correctly understood its independent judgment review function as to those findings in upholding them, the court determined that they were supported by the weight of the evidence. In the present case we do not have to assume that this occurred since at nine separate

places in the trial court's Statement of Decision, signed by Judge Cahill, he specifically stated that the weight of the evidence supported ALJ Lew's determination of issues based on the allegations of the various accusations. (App. 36, 42, 44, 51, 63, 64 (twice), 72 and 91 to the Petition.)

The question of whether Petitioner's due process rights were violated is really a review of whether the trial court truly exercised its independent judgment over the administrative decision below. Under the independent judgment test, by which a reviewing court independently determines issues of fact by reference to the administrative record, the function of the reviewing court is limited to ascertaining the presence, or absence, of the "weight" of the evidence in the record to sustain the trial court's findings, and if they are supported by substantial evidence, they are binding on appeal. (*Los Alamitos General Hospital, Inc. v. Director of Dept. of Health*, 86 Cal.App.3d 417, 423, 149 Cal.Rptr. 98 (1978).) As noted above, the trial court in at least nine separate places indicated that the weight of the evidence supported the findings of fact and determination of issues of the administrative tribunal.

The key is whether the administrative agency's findings are supported by the weight of the evidence, not whether the superior court judge reviewed every single exhibit, transcript line, etc. (*Lacy v. California Unemployment Ins. Appeals Bd.*, 17 Cal.App.3d 1128, 1132, 95 Cal.Rptr. 566 (1971); *Cleveland Chiropractic College v. State Bd. of Chiropractic Examiners*, 11 Cal.App.3d 25, 35, 89 Cal.Rptr. 572 (1970).)

II. ALTHOUGH NO EVIDENCE EXISTS THAT THE TRIAL COURT FAILED TO CONSIDER ALL EVIDENCE CITED TO IT BY PETITIONER BY THE TIME OF THE HEARING ON THE MOTION FOR A NEW TRIAL, ASSUMING *ARGUENDO* THAT IT DID, CASE LAW DOES NOT REQUIRE THE TRIAL COURT TO READ EVERY LINE OF EVERY PAGE OF THE ADMINISTRATIVE RECORD IN ORDER FOR IT TO EXERCISE ITS INDEPENDENT JUDGMENT

The seminal California case which expressly determined that mandamus was the appropriate method of challenging a license discipline by a state agency and which also explained what the scope of review on mandamus would be in such a case was *Drummey v. State Bd. of Funeral Directors*, 13 Cal.2d 75, 87 P.2d 848 (1939).

> "Although these [citations omitted] and other authorities establish that mandamus is the proper remedy to secure the restoration of a professional license of which the petitioner has been improperly deprived, where no other remedy exists, the authorities do not clearly establish the scope of review on mandamus." *Drummey, supra*, 13 Cal.2d 75, 82-83.

However, the Court in *Drummey* explicitly recognized that even under an independent judgment test review, the reviewing court was not acting entirely *de novo*.

> "This does not mean that the preliminary work performed by the administrative board in sifting the evidence and in making its findings is wasted effort. As was pointed out in the *St. Joseph Stockyards* case, [298 U.S. 38, 52, 56 S.Ct. 720 (1936)], in weighing the evidence the courts can and should be assisted by the findings of the

> board. The findings of the board come before the court with a strong presumption of their correctness, and the burden rests on the complaining party to convince the court that the board's decision is contrary to the weight of the evidence." *Drummey, supra,* 13 Cal.2d 75, 85.

The reasoning of *Drummey, supra,* was followed in *Dare v. Board of Medical Examiners,* 21 Cal.2d 790, 795 (1943) and *Moran v. Board of Medical Examiners,* 32 Cal.2d 301, 308 (1948).

The very language which Petitioner points out from footnote 10 in *Bixby, id.*, clearly places limitations on the independent judgment test. It is a *"limited trial de novo"*. (*Bixby v. Pierno,* 4 Cal.3d 130, 143 (1971); *see also, Guymon v. Board of Accountancy,* 55 Cal.App.3d 1010, 1013 (1976).) (Petition at p. 9.)

Thus, the test which the trial court applied in reviewing the decision of the Medical Board in the present case, which adopted the findings made by the ALJ, was the independent judgment test, in a *"limited trial de novo"* setting.

In *Bixby v. Pierno,* 4 Cal.3d 130, 143-144, fn. 10, 93 Cal.Rptr. 317 (1971), cited by Petitioner, the California Supreme Court characterized as arbitrary and capricious any administrative decision which has "no reasonable basis in law or no substantial basis in fact." In the case at issue, there is clearly a substantial basis in fact(s) for the discipline imposed on Petitioner.

Thus, Petitioner's contention that the trial court did not independently review the administrative record sufficiently to allow it to exercise its independent judgment is simply not true. This is fortified by several things.

First, as previously stated, during the first trial court appearance of February 6, 1997, on the Writ of Mandamus, the trial judge reminded petitioner that petitioner had been granted double the allowable number of pages under the local rules (40 pages in total) for his Memorandum of Points and Authorities in Support of the Petition. (Appendix Exh. "E".)

Second, due to the voluminous nature of the administrative record, in order to assist the trial court in reviewing it, when the Board filed its Memorandum of Points and Authorities in Support of Answer to the Petition for Writ of Mandamus, it attached as Exhibits B through G a verbatim recitation of the "Findings of Fact" and "Determinations of Issues" in regards to each finding made by the ALJ (App. 120-194 to the Petition) with supporting citations to the administrative transcript and written exhibits. (Appendix Exh. "C".) This painstakingly laborious task was undertaken to provide a simple "roadmap" for the trial court to expeditiously exercise its independent judgment of the record.

Third, during the hearing on the Motion for a New Trial the trial judge advised counsel for the petitioner and that he had looked at all of the cites in the briefs. (App. 3-4, fn. 1 to the Petition, Appendix Exh. "U".)

Finally, as the First District Court of Appeal correctly found, "[A]s Petitioner himself points out, petitioner actually reproduced and attached as an appendix to his original petition to the trial court the text of most of the material from the administrative record on which he relied in his writ petition. Thus, the trial court did not have to open all the actual reporters' transcripts of the administrative record in order to peruse the citations on

which petitioner was relying, since Petitioner had already provided the relevant texts as part of his own petition and the trial court could read them there. (App. 8 to the Petition.) The court went on to state that "[M]oreover, petitioner completely ignores the fact the trial court also had available to it literally thousands of pages of attached exhibits and documentary evidence contained in 22 additional volumes of administrative record accompanying his writ petition. Petitioner has never alleged that the trial court failed to review this evidence, and there is nothing to suggest that it did not do so." (App. 8 to the Petition.)

III. PETITIONER'S RELIANCE ON *SOLORIO* IS MISPLACED AND DOES NOT AFFECT REAL PARTY IN INTEREST'S JURISDICTION OVER HIS MEDICAL PRACTICE.

In *Solorio v. United States*, 483 U.S. 435, 107 S. Ct. 2924, 97 L.Ed.2d 364 (1987), the Supreme Court held that a *court-martial* convened pursuant to the Uniform Code of Military Justice (UCMJ) had jurisdiction over charges of sexual abuse by a serviceman even though the crimes were not "service connected." In essence, the court held that jurisdiction of a *court-martial* depends solely on the accused's status as a member of the Armed Forces, and not on the "service connection" of the offense charged, thus, overruling the holding in *O'Callahan v. Parker*, 395 U.S. 258, 89 S.Ct. 1683, 23 L.Ed2d 291 (1969).

Real Party in Interest would point out that Petitioner was not charged with a *criminal offense* by either the Navy under the Uniform Code of Military Justice or the laws of a state, as was the case in *Solorio, supra*. Further, the

record demonstrates that trial Judge Cahill clearly understood this issue, raised by Petitioner, when he stated:

> "[Real Party in Interest] clearly had jurisdiction over petitioner's acts or omissions as a physician. In the case of the one patient, M.G., who was treated by petitioner at Oak Knoll Naval Hospital, petitioner was practicing as a private practice physician away from the Naval Hospital at two separate facilities in San Leandro and Walnut Creek, California during the same relevant period of time. The evidence also shows that he had independently placed himself within the jurisdiction of respondent when he sought and secured California licensure as a physician when, had he only been practicing solely and exclusively as an employee of the Navy and provided medical services exclusively on a federal facility wholly supported and maintained by the U.S. Government, respondent could not have compelled him to secure such licensure. Finally, Business and Professions Code § 2305 clearly allows respondent to take action against one of its licensees where, as here, Oak Knoll Naval Hospital moved to restrict the authority of petitioner to practice medicine. Petitioner is only licensed as a physician in California and federal statutes clearly require that as a health care professional in the Naval armed services, petitioner is specifically required and depend on him having a current license to provide such care by grant of permissions from an official agency of, among others, a state. (See 10 U.S.C.A. § 1094, (a), (1) and (d), (1), (A).)" (App. 104-105, Order Denying Peremptory Writ of Mandate, to the Petition.)

Thus, Petitioner's contention that "*Solorio* holds that an active duty officer is under exclusive jurisdiction for disciplinary proceedings for any offenses committed while on active duty," in the present context, is totally inapplicable. (App. 27 to the Petition.)

Petitioner's additional contentions that the "unreviewed record" also impacted on whether a laches defense applied or that principles of res judicata or collateral estoppel" barred the charges against him because the Navy "cleared" him of such charges are also incorrect. (Petition, 19-20) Each of these issues was thoughtfully addressed by the Court.

> "In addition, the ALJ gave petitioner every opportunity to prove to him that the Navy proceedings actually alleged malpractice by petitioner for the care and treatment of patient M.G. and that there were specific findings made relative to said patient ***and petitioner could not do so.***" (Vol. XXII, 12:18-15:22, App. 95 to the Petition.) (Emphasis in the original.)

Finally, Petitioner's contention that "the lack of an independent review also materially affected DR. DAY'S laches claim" is also not supported by the evidence. (Petition at 20.) The trial court made very specific findings regarding this issue in its Statement of Decision. (App. 96-97 to the Petition.) After very carefully setting forth the applicable law regarding laches, the trial court concluded by finding that:

> "Petitioner herein has failed, both at the administrative level as well as before this Court, to meet this burden. Petitioner presented little, if any, persuasive evidence in this regard. This Court also finds that Respondent Medical Board

was not guilty of laches because it acted reasonably once it became aware of the facts giving rise to the various accusations against Petitioner and also because Petitioner was not prejudiced by any delay." (App. 97 to the Petition.)

IV. PETITIONER WAS NOT DISCIPLINED FOR MATTERS NOT ALLEGED IN WRITING.

Petitioner's allegation that he was disciplined for something that was not alleged in the accusations filed against him is incorrect. (Petition at 5, 29.) He alleges that "Administrative Finding 64 found that Petitioner allowed A.C.'s minor son 'to be responsible for administering Narcan in a syringe to her if needed', was never alleged in the accusations. (App. 91 and 187-188 to the Petition). Petitioner continues by alleging that "nowhere in the Second Supplemental Accusations regarding A.C. did this allegation appear." (Petition at 29.)

Petitioner cites to *In re Ruffalo* 390 U.S. 544, 551, 20 L.Ed.2d 117 (1968) for the proposition that "The charge must be known before the proceedings commence."

In this case, that is precisely what occurred. In fact, the California Administrative Procedure Act, which governs administrative disciplinary proceedings, sets forth the requirement in this fashion, "The accusation shall be a written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his defense. It shall specify the statutes and rules which the respondent is alleged to have violated, but shall not consist merely of

charges phrased in the language of such statutes and rules." (California Gov't Code § 11503.)

A review of the actual language of the charging accusations in question quickly points out that the charges in the accusation were quite specific and more than amply served to place Petitioner on notice of the charges against him. The Second Supplemental Accusation filed against him specifically set forth allegations and a cause for discipline for this conduct. (App. 63, 70, and 75-76.) *See*, Second Supplemental Accusation, Para. 32:11-21, Para. 49:14-17, Para. 49(k):21-30:7.)

He allowed and taught the 14 year old son of a patient, whom he disingenuously described in the medical records only as the patient's "attendant," to inject his mother, should she experience a narcotic overdose, with the narcotic antagonist, Narcan. (Vol. IV, 55:6-57:7, Admin. Exh. 86, Medical Records of Patient A.C., pp. 856, 1184.)

One of the Board's expert witnesses, whom Petitioner cross-examined extensively, described this scenario as "incredulous" and "almost in a category of being ridiculous." (Vol. IX, 79:12-23.)

Finally, petitioner alleges that "[N]othing in the record stated that the son was responsible for administering Narcan to A.C.," his mother. (Petition at 30.) This is simply untrue. Petitioner, himself, testified at the hearing:

> "So we – her son was with her, and so she was – the syringe was given to her son. We drew up the medication, and all he would have had to have done, should she felt those symptoms, was to somehow get that needle under the skin, after wiping off the skin with alcohol, and inject the amount in the syringe.

> The only way he could have hurt her would be if he had have injected that into her eye, something that was probably quite unlikely. The reason for that was that the needle was not long enough to get into any other vital structures where the needle itself could have done any damage." (Vol. XX, 48:25-49:12.)

The only thing missing from the allegations of the accusation was the exact age of the 14 year-old son, since this was unknown to Real Party in Interest. (Appendix Exh. "U", Reporter's Transcript of Proceedings at Motion for New Trial Hearing, 14:9-15:10.) The reason that it was unknown to Real Party in Interest was because Petitioner had failed to note it in the medical record, instead choosing to describe the 14 year-old son as an "attendant".

CONCLUSION

A review of the Statement of Decision issued by the trial court quickly points out that the court was well aware of its duties under the law as well as the specific evidence of the case, as was pointed out by the trial court, following its review of the administrative record:

> "There was sufficient evidence presented by way of the Board's expert witnesses, one Board Certified Orthopedic Surgeon; one Board Certified Neurologist and two Board Certified Anesthesiolgists, that petitioner's care and treatment of the six patients alleged in the various accusations failed to fall within the prevailing standards of practice as found in the ALJ's PROPOSED DECISION, adopted by [Real Party in Interest] Medical Board. See *Cooper v. Board of Medical Examiners*, 49 Cal.App.3d 931, 941, 123

> Cal.Rptr. 563 (1975); *Gore v. Board of Medical Quality Assurance*, 110 Cal. App. 3d 184, 198, 167 Cal.Rptr. 881 (1980). Finally, in reviewing the findings of the Board, it should be noted that the *burden* rests on the complaining party to convince the court that the Board's decision is contrary to the weight of the evidence. (*Drummey v. State Bd. of Funeral Directors*, 13 Cal.2d 75, 84-85, 87 P.2d 848 (1939)). It is established that the "weight of the evidence" is synonymous with "a preponderance of the evidence" (*Chamberlain v. Ventura Co. Civil Service Comm'n*, 69 Cal.App.3d 362, 138 Cal.Rptr. 155 (1977)). Petitioner herein has failed to meet his burden of proving that [Real Party in Interest's] decision against him is contrary to the weight of the evidence." (App. 97-98 to the Petition.)

Further, the trial court found that the Administrative Law Judge had discharged his duties in an exemplary fashion.

> "The decision is extremely detailed and well reasoned. Over the course of 22 days of hearing, ALJ Lew was able to carefully gauge the expertise, credibility and demeanor of the witnesses who testified before him, including Petitioner, the five patients who appeared at the hearing as well as numerous expert witnesses called by both parties. ALJ Lew then proceeded to make specific written findings thereon which clearly set forth for all interested parties what his thought and deliberative process was between the raw evidence, his findings of fact, determination of issues and decision as to ultimate disposition. ALJ Lew demonstrated in his written decision an extensive knowledge of the law,

the medical issues involved and his duties pursuant to the law." (App. 100 to the Petition.)

For all of the foregoing reasons, the petition for writ of certiorari should be denied.

BILL LOCKYER, Attorney General
of the State of California

CARLOS RAMIREZ, Senior
Assistant Attorney General

VIVIEN HARA HERSH
Supervising Deputy Attorney
General

ALFREDO TERRAZAS
Deputy Attorney General
(*Counsel of Record*)

Counsel for Respondent

Brief in Opposition – Appendix

Table of Contents

Page

Original Accusation (Patient M.O.) February 1994 .....App. 1

First Supplemental Accusation (Patients M.G., M.H., and B.C.) February 1995.....App. 22

Second Supplemental Accusation (Patients J.W. and A.C.) October 1995.....App. 47

LEONE California Supreme Court Opinion April 2000 .....App. 78

LEONE Order August 2000 .....App. 107

Remittitur November 2000 .....App. 112

Petitioner's Letter to Ct. of Appeal November 2000 .....App. 114

Court of Appeal Letter to Petitioner December 2000 .....App. 118

Statutory Provisions .....App. 120

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS
Deputy Attorney General
455 Golden Gate Avenue, Suite 6200
San Francisco, CA 94102
Telephone: (415) 703-1971

Attorneys for Complainant

BEFORE THE MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	No. D-5613
Franklin Jerome Day, M.D. P. O. Box 306 San Leandro, California 94577 Certificate No. G-39260	ACCUSATION
Respondent.	

DIXON ARNETT, complainant herein charges and alleges as follows:

1. He is the Executive Director of the Medical Board of California, State of California (hereinafter "the Board") and makes these charges and allegations solely in his official capacity.

LICENSE HISTORY

2. At all times material herein, respondent, Franklin Jerome Day, M.D., (hereinafter "respondent") has held physician and surgeon certificate No. G 39260, which was

issued to him by the Board on May 18, 1979. Said certificate is in good standing at the present time and expires on March 31, 1995. No prior disciplinary action has been taken against said certificate. Respondent is a supervisor of a physician assistant, however, his supervisor physician assistant license No. SA 14333 is in a delinquent status with an expiration date of May 31, 1988.

STATUTES

3. Section 2001 of the Business and Professions Code[1] provides for the existence of the Board.

4. Section 2003 of the code provides for the existence of the Division of Medical Quality (hereinafter referred to as the "division") within the Board.

5. Section 2004 of the code provides, inter alia, that the division is responsible for the administration and hearing of disciplinary actions involving enforcement of the Medical Practice Act (Section 2000, et seq.) and the carrying out of disciplinary action appropriate to findings made by a medical quality review committee, the division, or an administrative law judge with respect to the quality of medical practice carried out by physician and surgeon certificate holders.

6. Sections 2220, 2227 and 2234 of the code, together provide that the division shall take disciplinary action against the holder of a physician's and surgeon's certificate who is guilty of unprofessional conduct.

---

[1] All statutory references are to the Business and Professions Code unless otherwise indicated.

7. Section 2220 of the code provides that:

> . . . except as otherwise provided by law, the Division of Medical Quality may take action against all persons guilty of violating this chapter. The division shall enforce and administer this article as to physician and surgeon certificate holders, and the division chapter for these purposes including, but not limited to:
>
> (a) Investing complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct.

8. Section 2227 of the code provides that a licensee whose matter has been heard by the Division of Medical Quality, by a medical quality review committee or a panel of such committee, or by an administrative law judge, or whose default has been entered, and who is found guilty may, in accordance with the provisions of this chapter:

(a) Have his or her certificate revoked upon order of the division.

(b) Have his or her right to practice suspended for a period not to exceed one year upon order of the division or a committee or panel thereof.

(c) Be placed on probation upon order of the division or a committee or panel thereof.

(d) Publicly reprimanded by the division or a committee or panel thereof.

(e) Have such other action taken in relation to discipline as the division, a committee or panel thereof, or an administrative law judge may deem proper.

9. Section 2234 of the code provides, in relevant part, that the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

10. Section 725 of the code provides, in pertinent part, that repeated acts of clearly excessive prescribing or administering of drugs or treatment as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon.

11. Section 2238 provides that a violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct.

12. Section 2241 provides, in pertinent part, that unless otherwise provided by this section, the prescribing, selling, furnishing, giving away, or administering or offering to prescribe, sell, furnish, give away , or administer any of the drugs or compounds mentioned in Section 2239 to an addict or habitue constitutes unprofessional conduct.

13. Section 2242(a) provides as follows:

> "(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4211 without a good faith prior examination and

medical indication therefor, constitutes unprofessional conduct."

14. Section 11152 of the Health and Safety Code provides that no person shall write, issue, fill, compound, or dispense a prescription that does not conform to this division.

15. Section 11153, subdivision (a) of the Health and Safety Code provides that a prescription for controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized methadone maintenance program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

16. Section 11156 of the Health and Safety Code provides that no person shall prescribe for or administer, or dispense a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division.

17. Section 11157 of the Health and Safety Code provides that no person shall issue a prescription that is false or fictitious in any respect.

18. Section 11171 of the Health and Safety Code provides that no person shall prescribe, administer, or furnish a controlled substance except under the conditions and in the manner provided by this division.

19. Section 11210 of the Health and Safety Code provides, in pertinent part that a physician . . . may prescribe for, furnish to, or administer controlled substances to his patient when the patient is suffering from a disease, ailment, injury, or infirmities attendant upon old age, other than addiction to a controlled substance.

The physician . . . shall prescribe, furnish, or administer controlled substances only when in good faith he believes the disease, ailment, injury, or infirmity, requires such treatment.

The physician . . . shall prescribe, furnish, or administer controlled substances only in such quantity and for such length of time as are reasonably necessary.

20. Article 2 of Chapter 5 of Division 10 of the Health and Safety Code provides, in pertinent part, as follows:

Article 2. Treatment of Addicts for Addition

> 11215. Except as otherwise provided in this section, any narcotic controlled substance employed in treating an addict for addiction shall be administered by a physician, or by a registered nurse acting under his instruction. . . .

11216. Except as otherwise provide din Section 11215, no physician or other person shall order, permit, or direct any person other than a registered nurse, or other physician, to administer a narcotic controlled substance to a person being treated for addiction to a controlled substance.

11217. No person shall treat an addict for addiction to a narcotic drug except in one of the following:

(a) An institution approved by the State Department of Mental Health, and where the patient is at all times kept under restraint and control.

(b) A city or county jail.

(c) A state prison.

(d) A facility designated by a county and approved by the State Department of Mental Health pursuant to Division 5 (commencing with Section 5000) of the Welfare and Institution Code.

(e) A state hospital.

(f) A county hospital.

(g) A facility licensed by the State Department of Alcohol and Drug Programs pursuant to Division 10.5 (commencing with Section 11750).

Methadone in the continuing treatment of addiction to a controlled substance shall be used only in those programs licensed by the State Department of Alcohol and Drug Programs pursuant to Article 3 (commencing with Section 11875) of Chapter 1 of Part 3 of

Division 10.5 on either an inpatient or outpatient basis, or both.

This section does not apply during emergency treatment, or where the patient's addiction is complicated by the presence of incurable disease, serious accident, or injury, or the infirmities of old age.

Neither this section nor any other provision of this division shall be construed to prohibit the maintenance of a place in which persons seeking to recover from addiction to a controlled substance reside and endeavor to aid one another and receive aid from others in recovering from such addiction, nor does this section or such division prohibit such aid, provided that no person is treated for addiction in such place by means of administering, furnishing, or prescribing of controlled substances. The preceding sentence is declaratory of preexisting law.

Neither this section or any other provision of this division shall be construed to prohibit short-term methadone detoxification treatment in a controlled setting approved by the director and pursuant to rules and regulations of the director. Facilities and treatment approved by the director under this paragraph shall not be subject to approval or inspection by the Board of Medical Quality Assurance, nor shall persons in such facilities be required to register with, or report the termination of residence with, the police department or sheriff's office.

11217.5 Notwithstanding the provisions of Section 11217, a licensed physician and surgeon may treat an addict for addiction in any office or

medical facility which, in the professional judgment of such physician and surgeon, is medically proper for the rehabilitation and treatment of such addict. Such licensed physician and surgeon may administer to an addict, under his direct care, those medications and therapeutic agents which, in the judgment of such physician and surgeon, are medically necessary, provided that nothing in this section shall authorize the administration of any narcotic drug.

11218. A physician treating an addict for addiction shall not prescribe for or furnish the addict more than any one of the following amounts of controlled substances during each of the first 15 days of such treatment.

(a) Eight grains of opium.

(b) Four grains of morphine.

(c) Six grains of Pantopon.

(d) One grain of Dilaudid.

(e) Four hundred milligrams of isonipecaine (Demerol).

(f) One hundred eighty milligrams of methadone.

11219. After 15 days of treatment the physician shall not prescribe for or furnish to the addict more than any one of the following amounts of controlled substances during each day of such treatment:

(a) Four grains of opium.

(b) Two grains of morphine.

(c) Three grains of Pantopon.

(d) One-half grain of Dilaudid.

(e) Two hundred milligrams of isonipecaine (Demerol).

(f) One hundred eighty milligrams of methadone.

11220. At the end of 30 days from the first treatment, the prescribing or furnishing of controlled substances, except methadone, shall be discontinued.

11221. The physician prescribing, furnishing, or administering any narcotic controlled substance in the treatment of an addict for addiction shall within five days after the first treatment report by registered mail, over his signature, to the Attorney General stating the name and address of the patient, and the name and quantities of narcotic controlled substances prescribed.

The report shall state the progress of the patient under the treatment.

The physician shall in the same manner further report on the 15th day of the treatment and on the 30th day of the treatment, and thereafter shall make such further reports as are requested in writing by the Attorney General.

11222. In any case in which a person is taken into custody by arrest or other process of law and is lodged in a jail or other place of confinement, and there is reasonable cause to believe that such person is addicted to a controlled substance, it is the duty of the person in charge of the place of confinement to provide the person so confined with medical aid as necessary to

ease any symptoms of withdrawal from the use of controlled substances.

In any case in which a person, who is participating in a methadone maintenance program, is incarcerated in a jail or other place of confinement, he shall, in the discretion of the director of such program, be entitled to continue in such program until conviction.

DRUGS

21. Anesthetics (Parenteral-Local) are given by injection to cause loss of feeling before and during surgery, dental procedures (including dental surgery), or labor and delivery. These medicines do not cause loss of consciousness. Marcaine, a trade name for Bupivacaine; Nesacaine, a trade name for Chloroprocaine and Xylocaine, a trade name for Lidocaine; are anesthetics and all dangerous drugs as defined in section 4211 of the code.

Colchicine, used primarily to relieve inflammation, pain and swelling associated with gout or gouty arthritis, is a dangerous drug as defined in section 4211 of the code.

Demerol, a trade name for Pethidine or Meperidine is a dangerous drug as defined by section 4211 of the Business and Professions Code, and is a Schedule II controlled substance as defined in section 11055(c)(16) of the Health and Safety Code and is a Schedule II controlled substance as defined in section 1308.12(c)(16) of Title 21 of the Code of Federal Regulations.

Depo-Medrol, a trade name for Methylprednisolone Acetate, when used as a Adrenocorticoid is used to provide relief for inflamed areas of the body and is a dangerous drug as defined in section 4211.

Elavil, a trade name for Amitriptyline, is a tricyclic antidepressant and a dangerous drug as defined by section 4211 of the code.

Methadone Hydrochloride, aka brand names Dolophine, Methadose and Physeptone, is a dangerous drug as defined in section 4211 of the code and a schedule II controlled substance as defined in section 11055(c)(13) of the Health and Safety Code.

Morphine Sulfate, aka brand names Astramorph, Duramorph, MSIR, RMS Uniserts and Rozanol, is a dangerous drug as defined in section 4211 of the code and a Schedule II controlled substance as defined in section 11055(b)(1)(M) of the Health and Safety Code.

Naprosyn, a trade name for Naproxen, is a dangerous drug as defined in section 4211 of the code.

Parafon Forte, a trade name for the combined generic substance Chlorzoxazone and Acetaminophen, is used to relax certain muscles in the body and relieve the pain and discomfort caused by strains, sprains or other injuries to the muscles. It is a dangerous drug pursuant to section 4211 of the code.

Prednisone, when used as a Adranocorticoid is used to provide relief for inflamed areas of the body and is a dangerous drug as defined in section 4211.

Talacen, a trade name for the generic combination of Pentazocine Hydrochloride and Acetaminophen, is a narcotic analgesic and a controlled substance as defined in schedule IV, section 11507(g)(1) of the Health and Safety Code. Talacen is a dangerous drug as defined in section 4211 of the code.

Valium, a trade name for diazepam, is a dangerous drug as defined by section 4211 of the Business and Professions Code, and is a Schedule IV controlled substance as defined in section 11057(d)(7) of the Health and Safety Code.

Vistaril, a trade name for Hydroxyzine Pamoate, is a dangerous drug as defined by section 4211 of the Business and Professions Code.

Vicodin is the trade name for 5 mg Hydrocodone Bitartrate and 500 mg Acetaminophen and is a controlled substance as defined in Schedule III, section 11056(e)(5) of the Health and Safety Code. Zydone and Vicodin ES are other trade names for Hydrocodone with Apap (Narcotic Analgesic with Acetaminophen). Vicodin, Vicodin ES and Zydone are all dangerous drugs as defined in section 4211.

Xanax, a trade name for Alprazolam, is a dangerous drug as defined in section 4211 and a schedule IV controlled substance as defined by section 1308.14 (c) (1) of Title 21 of the Code of Federal Regulations.

FIRST CAUSE FOR DISCIPLINARY ACTION

22. At all times relevant hereto, respondent was practicing as a physician and surgeon in Walnut Creek, California doing business as Pain Relief Center.

23. Beginning on or about January 23, 1987, respondent first saw female patient M.O.[2], who was 35 years old at said time, for complaints of a work related injury. The patient was a former body builder and aerobics instructor who was disabled from her position as a freight cashier. In April of 1985 she twisted her neck while carrying a heavy load of files. She was startled by gunshots near to her from a bank robbery apparently in progress. She reported hearing a pop in her neck and within 24-48 hours had neck pain radiating into her arm.

Patient M.O. was initially treated by a chiropractor who sent her to undergo a neurological evaluation. She eventually underwent a cervical discectomy in September of 1985 at the C5-6 level with an anterior fusion. MRI scans documented a herniated disc at this level prior to surgery. A trial of trigger point injections prior to surgery had been of transient but significant help.

Following the 1985 surgery patient M.O. did have gradual improvement in sensation in the left arm and hand but did not have lessening of pain. She continued with physical therapy, which had been tried before the surgery, and returned to work for 2 months beginning in February of 1986. She did have to leave work because of

---

[2] The name of the patient will be made known to the respondent at the time of discovery in this case.

pain and continued to do poorly when she was first seen by respondent in January of 1987.

24. Patient M.O.'s treatment with respondent extended over the period January of 1987 through October of 1987. When first seen by respondent, patient M.O. was depressed and tearful and was being treated with oral narcotic medications. Within the first few months of respondent's treatment of her, she was being followed by a psychiatrist, Dr. Gracier, and was evaluated by a neurosurgeon, Dr. Rosario, on respondent's referral.

Between January 23, 1987 and October 27, 1987, respondent saw patient M.O. on approximately 56 occasions. On the occasion of her first office visit, respondent fitted the patient with a temporary epidural catheter below the area of her marked tenderness at the T-2 level.

During the period January through August, 1987, the time prior to her hospitalization with possible meningitis due to infection at the site of the epidural catheter, respondent performed approximately 8 epidural local anesthetic or epidural differential local anesthetic blocks, 26 epidural steroid injections, 9 stellate ganglion blocks with local anesthetic, 12 sets of trigger point injections, 1 BIER block in the affected extremity, and approximately 72 days of daily epidural opiate injections.

On numerous office visits more than one procedure was performed such as a stellate ganglion block in addition to trigger point injections or in addition to an epidural injection. During June, July and August of 1987, an epidural catheter was in place nearly continuously. It was changed on the average of a few times each month though not dictated by a regular schedule but rather

within the limitations of the catheter itself including times where the catheter was pulled out too far or otherwise was associated with inflammation or nonfunctioning. Patient M.O. self-injected Duramorph, on respondent's directions and prescriptions, during this period of time in addition to receiving other blocks from respondent.

25. The practices described in paragraphs 23 and 24 hereinabove resulted in complications for patient M.O. The combination of (1) more than 20 epidural steroid injections in an 8 month period, and (2) prolonged nonsurgical placement of an epidural catheter for epidural opiates (including Morphine), with the patient self-injecting the catheter, produced a "Cushingoid" appearance in said patient M.O. and "Adison's Disease". Said manifestations and disease were induced by the use of steroids over a long period of time followed by adrenal insufficiency when the frequency of injections was reduced ultimately resulting in hospitalization of the patient at Providence Hospital of Oakland from November 13 through 18, 1987 for the treatment of Addison's Disease.

Further, the prolonged use of an epidural catheter eventually also resulted in local cellulitis and epidural inflammation adjacent to the dura which, by definition, is Meningitis. From September 11 through 19, 1987, said patient was hospitalized at Los Medanos Community Hospital for approximately 8 days for treatment of spinal meningitis (epidural infection) and removal of the cervical catheter. During this hospitalization the patient also suffered from withdrawal from the morphine which she

had been receiving from respondent in the form of injections directly into the epidural catheter as well as the self-administration of morphine, begun under orders of respondent.

26. Respondent treated patient M.O. and prescribed and/or administered controlled substances and/or dangerous drugs, as identified in paragraph 21 hereinabove, and/or treatments to said patient in clearly excessive amounts without performing a good faith medical examination and/or without a medical indication for the prescribing of the controlled substances and/or dangerous drugs and/or treatments as follows:

> Over the course of 8 months, from January 1987 through August 1987, the period prior to her hospitalization for catheter related epidural infection, respondent treated patient M.O. by providing her with:
>
> - epidural local anesthetic or differential local anesthetic blocks (8 injections);
> - epidural steroids (26 injections);
> - stellate ganglion blocks (9 injections);
> - BIER block (1 injection);
> - Daily epidural opiate injections (Minimum of 72 days).

27. In addition to the above listed treatments provided and/or administered by respondent directly to patient M.O., respondent also knew that the patient had sought and received additional amounts of injectable Morphine Sulfate from him during said period of time where he had instructed the patient and her husband on

how to inject said opiate medications through an epidural catheter.

28. In diagnosing, caring for and treating patient M.O. during said time, respondent failed to recognize and act on the implications of the treatment modalities he employed with her including the following:

A. Respondent, in a grossly negligent and/or negligent and/or incompetent manner, employed the use of multiple epidural steroid injections in an excessive manner which directly led to the suppression of the hypothalamic pituitary adrenal axis in patient M.O., hence the development of Addison's Disease.

B. Respondent, in a grossly negligent and/or negligent and/or incompetent manner, failed to design an adequate long-term treatment plan for patient M.O. deciding instead on performing invasive procedures, from one office visit to the next, dictated by short-term responses only.

C. Respondent, in a grossly negligent and/or negligent and/or incompetent manner, used morphine, on an ongoing basis, to control patient M.O.'s pain. The use of morphine, on a long-term basis, for chronic pain in a patient with chronic cervical discomfort post-operatively, in the face of polylitigenous environments, is outside the standard of practice of California licensed practitioners.

D. Respondent, in a grossly negligent and/or negligent and/or incompetent manner, employed the prolonged use of temporary catheters in the care and treatment of patient M.O.

E. Respondent, in a grossly negligent and/or negligent and/or incompetent manner, taught, encouraged and allowed patient M.O. to self-inject opiate medications through an epidural catheter, all in addition to the epidural injections of opiate medications administered by respondent.

F. Respondent, in a grossly negligent and/or negligent and/or incompetent manner, injected and issued prescriptions to patient, M.O., and authorized refills of prescriptions to patient, M.O. for the "controlled substance" and "dangerous drug" Morphine in large quantities for complaints of neck and shoulder pain which resulted in patient, M.O., becoming addicted to Morphine.

G. Further, after respondent belatedly realized that patient, M.O., had become addicted to Morphine, he provided her with Methadone and Valium in an effort to help her with her dependance on the Morphine. Patient M.O. was admitted to Providence Hospital on November 11, 1987, following her treatment by respondent, where she was successfully tapered off the Methadone and Morphine.

29. Respondent's conduct as alleged in paragraphs 23 through 28, detailing the treatment and professional care provided to patient M.O., constitutes gross negligence and/or repeated negligent acts and/or incompetence and is grounds for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and (d).

30. Further, respondent's conduct as alleged in paragraphs 23 through 28, detailing the treatment and

professional care provided to patient M.O., constitutes repeated acts of clearly excessive prescribing or administering of drugs (controlled substances and dangerous drugs) and/or treatments as determined by the standard of the community of licensees in violation of section 725 of the Code subjecting Respondent's certificate number G 39260 to discipline for unprofessional conduct pursuant to section 2234 of the Code.

SECOND CAUSE FOR DISCIPLINARY ACTION

31. The allegations of the First Cause for Disciplinary Action hereinabove are hereby incorporated by reference.

32. Respondent's conduct as alleged in the First Cause for Disciplinary Action constitutes unprofessional conduct and the furnishing of a controlled substance(s) (Morphine, Methadone) to a known addict or habitué without legitimate medical purpose and solely for the purpose of providing the user with controlled substances sufficient to keep her comfortable by maintaining her customary use. This conduct is in violation of Health and Safety Code sections 11007, 11153, 11154(a), 11156 and 11171. Further, this conduct constitutes cause for disciplinary action pursuant to sections 2234, 2238 and 2241 of the Business and Professions Code.

WHEREFORE, complainant requests that the Board hold a hearing on the matters hereinabove alleged and after that hearing issue an order suspending or revoking physician's surgeon's certificate No G 39260, heretofore issued to Respondent Franklin Jerome Day, M.D., and

taking such other and further action as is deemed just and proper.

Dated: 2-2-94

/s/ Dixon Arnett
DIXON ARNETT
Executive Director
Medical Board of California
State of California
Complainant

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS, STATE BAR No. 78403
Deputy Attorney General
2101 Webster Street, 12th Floor
Oakland, CA 94612-3049
Telephone: (510) 286-3795

Attorneys for Complainant

BEFORE THE MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	No. D-5613
Franklin Jerome Day, M.D. P. O. Box 306 San Leandro, California 94577 Certificate No. G-39260	)	FIRST SUPPLEMENTAL ACCUSATION
Respondent.	)	

DIXON ARNETT, complainant herein charges and alleges as follows:

1. He is the Executive Director of the Medical Board of California, State of California (hereinafter "the Board") and makes these additional charges and allegations to be added to the charges and allegations contained *In the Matter of the Accusation Against: FRANKLIN JEROME DAY, M.D.*, filed on February 2, 1994, solely in his official capacity.

THIRD CAUSE FOR DISCIPLINARY ACTION

2. At all times relevant to the allegations in this accusation regarding patient M.G., respondent was practicing as a physician and surgeon at the Oak Knoll Naval Hospital located in Oakland, California as the Director of the Pain Clinic at said hospital.

3. Beginning at a time presently unknown but believed to be shortly prior to October 18, 1991, respondent first saw male patient M.G., d.o.b. 10/02/62, a then 30 year old patient who was complaining of chronic, acute and recurrent back pain. The patient was a Naval employee in 1988 when he injured his lower back helping to unload a Medivac flight.

4. Patient M.G. had a relevant prior medical history as follows, in June of 1988 the patient underwent a Laminectomy (Hemilaminectomy) for decompression of his nerve root at L5 & S1. In December of 1988, due to continued pack pain, patient M.G. underwent a second Laminectomy which included a two level fusion (L4, L5 & S1) with a bone graft. While this second surgical procedure provided patient M.G. with some relief from his chronic back pain, he was subsequently hospitalized from July 22 to July 24, 1991 due to spinal instability, low back pain and left leg pain.

5. Beginning at a time presently unknown but believed to be shortly prior to October 18, 1991, patient M.G. was seen for the first time by respondent at the Pain Clinic at Oak Knoll Naval Hospital in Oakland for a consultation. The Consultation report reads, in its entirely, as follows: "29 year old status post two level laminectomy and fusion, now with positional sharp pain

and (illegible). Pain probably non-union related. Has failed epidural steroids in past times five. Will try Methadone – if fails consider diagnostic block." On this date began a course of care and treatment by respondent, and his subordinate staff at the Pain Clinic at Oak Knoll Naval Hospital, for patient M.G. where he was prescribed, in increasing amounts, a powerful narcotic Methadone Hydrochloride, without any adjunctive physical therapy or medications. At the inception of pain medication treatment with Methadone by respondent and his associates, patient M.G. was reporting good results taking 2 to 4, five (5) mg tablets per day which escalated to approximately 150 mg per day, (30, five (5) mg tablets per day), at the time of his admission into a detoxification program in July of 1993.

6. Thereafter, on or about August 20, 1992 the patient was seen at the Palo Alto Veteran's Administration Hospital Pain Management Clinic where a diagnosis was deferred and the patient denied any substance abuse problem.

7. On or about October 19, 1992 patient M.G. underwent a third surgical back procedure, a repeat transverse process fusion L4 to L5. The patient was hospitalized from October 18 to October 27, 1992 when he was discharged in a full body cast. After the full body case was apparently removed by patient M.D. himself and re-fitted by hospital personnel, it was finally removed on or about January 22, 1993.

8. On or about April 30, 1993 patient M.G. was seen at the Neurosurgery Clinic at the Veteran's Administration Hospital in Palo Alto where he indicated that he was

being withdrawn from his Methadone medications in a Methadone Detoxification Program.

9. On or about July 26, 1993 patient M.G. was admitted, via an elective admission, to the Oak Knoll Naval Hospital in Oakland for Methadone withdrawal. The records for this hospitalization indicate that this the patient has had two prior unsuccessful attempts to stop Methadone. The first prior withdrawal attempt was complicated by violent behavior, diarrhea and nausea. The second prior withdrawal attempt, which included the use of Clonidine, was complicated by increased lethargy and insomnia. At the inception of this third withdrawal attempt at Naval Hospital Oakland (NHO), patient M.G. was started on 100 mg of Methadone per day along with Clonidine at .1 mg twice a day. The hospitalization included a decreasing taper of 10 mg per day of Methadone as well as physical therapy two times per day. At the time of discharge, on August 5, 1993, patient M.G. had been off of Methadone for two days and he was immediately accepted into a prescription drug rehabilitation program.

10. On or about August 5, 1993 patient M.G. was transferred from NHO to CPC Fremont Hospital for continued inpatient prescription drug rehabilitation therapy. While patient M.G. had been rapidly detoxified from Methadone within the preceding two weeks prior to admission, it was decided to accept him into the inpatient program at CPC Fremont Hospital because it was felt that he was not completely clear. Patient M.G. was started on a detoxification protocol using Buprenex sublingually as well as Valium for sedation and muscle relaxation. Shortly thereafter patient M.G. began refusing

medications and left the hospital, against medical advise, on or about August 7, 1993.

11. On or about August 9, 1993 patient M.G. was admitted to CPC Fremont Hospital for a second attempt at the prescription drug rehabilitation program. At the time of this second admission, laboratory tests confirmed positive results for Methadone use by the patient between the date of his previous discharge (August 7, 1993) and the beginning of this admission. Patient M.G. was restarted on a detoxification protocol using Buprenex and at the time of his discharge, on August 17, 1993, he was transferred into a partial hospitalization (PHP) as far as his follow care for his drug addiction and back to NHO for follow up care for his ongoing back problems.

12. In diagnosing, caring for and treating patient M.G. during said time, respondent acting either alone or in supervision of those subordinate to him did so in a grossly negligent and/or negligent and/or incompetent manner as follows:

A. Respondent failed to perform a complete history and physical examination of patient M.G. during the initial patient visit.

B. Respondent specifically failed to record a history which included a description of the pain, its location, aggravating and relieving factors, effects on the patient's lifestyle and activities of daily living, a complete past medical history which would include other medications and treatments previously tried and cu rently in use and a history of alcohol or drug dependence.

C. Respondent specifically failed to perform a physical examination which noted the limitations caused by the pain. Although pain can only be evaluated in subjective terms, objective physical findings are useful to determine if the patient is making progress towards a more functional lifestyle.

D. By failing to perform a complete physical examination which noted the limitations caused by the pain, respondent could not, and did not, initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment. If the patient shows no improvement in his functional abilities, then a different treatment plan should be instituted.

E. By failing to institute an objective, measurable treatment plan for patient M.G., respondent could not, and did not, evaluate the patient at periodic intervals, using the original history and physical as a baseline.

F. Respondent failed to use other medications or treatment modalities, commonly used by pain management physicians for treatment of neuropathic pain such as tricyclic antidepressants, antiseizure medications, physical therapy to improve range of motion and muscle strength and to help evaluate the patient's progress, and psychologic counseling and support if available.

G. Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient M.G. to self administer Methadone, on an as needed basis. Methadone is not prescribed in a p.r.n. manner as was done with patient M.G., but in a stated milligram dose every six or eight hours. When a patient continues to have problems maintaining the dosing

schedule and is reporting that he lost pills or coming up with other excuses, as noted in this patient's chart, then psychologic evaluation should be sought before continuing the narcotic program.

13. Respondent's conduct as alleged in paragraphs 2 through 12, detailing the treatment and professional care provided to patient M.G., constitutes gross negligence and/or repeated negligent acts and/or incompetence and is grounds for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and/or (d).

14. Further, respondent's conduct as alleged in paragraphs 2 through 12, detailing the treatment and professional care provided to patient M.G., constitutes repeated acts of clearly excessive prescribing or administering of drugs (Methadone) as determined by the standard of the community of licensees in violation of section 725 of the Code subjecting respondent's certificate as a physician and surgeon to discipline for unprofessional conduct pursuant to section 2234 of the Code.

FOURTH CAUSE FOR DISCIPLINARY ACTION

15. At all times relevant hereto, respondent was practicing as a physician and surgeon in San Leandro, California doing business as Pain Relief Center.

16. Beginning on or about January 29, 1993, respondent first saw female patient M.H., who was 39 years old at said time, when she first filled out the Intake History Questionnaire, for complaints of sever recalcitrant low

back pain with occasional leg pain. The patient was disabled from her involvement in an earlier vehicle related injury and also was suffering from severe depression at the time of her first office visit with respondent. In April of 1983 she was involved in an automobile accident from which she was unable to stand up straight, secondary to pain, for a period of about 2 years. She was seen by many different physicians including evaluation at St. Mary's Spine Center very early on. Her pain continued unabated during this entire time. Over the years, and before consulting with respondent, she had approximately 7-8 epidural steroid injections with varying esults [sic] (some seemed to make her pain somewhat better although none ever made her pain go away, even for a brief period). In addition, prior to seeing respondent, patient M.H. had tried medication protocols including Vicodin and anti-inflammatories as well as Acupuncture and Chiropractic.

17. At the time of her first office visit with respondent, patient M.H. advised respondent that she was currently taking medications including;

> Mellaril (Mellaril is a trade name for the generic substance Thioridazine Hydrochloride, and) is a dangerous drug under section 4211 of the Business and Professions Code) for an Obsessive/ Compulsive Personality Disorder and for hearing occasional voices;
>
> Doral (Doral, a trade name for the generic substance Quazepam, a trifluoroethyl benzodiazepine hypnotic agent, and) [sic] is a dangerous drug as defined by section 4211 of the Business and Professions Code, and is a Schedule IV controlled substance as defined in section 11057(d)(22) of the Health and Safety

Code) for help in sleeping and; Zoloft (Zoloft, a trade name for Sertraline Hydrochloride, an antidepressant unrelated to tricyclic, tetracyclic or other available antidepressant agents, and) [sic] is a dangerous drug as defined by section 4211 of the Business and Professions Code) for major depressive disorder.

18. Prior to her visit to respondent's office on January 29, 1993, patient M.H. had a history of psychosis, depression and suicidal ideation and attempts. She had seriously considered suicide and had attempted suicide on two different occasions. She had been treated with electric shock therapy as a result. Patient M.H. had just recently returned to work and reported that her pain had worsened since returning to work. She reported her pain to be about a 7 on the 0-10 scale, although she had not undergone any surgical intervention before seeing respondent.

19. Patient M.H.'s actual treatment with respondent extended over the period from February 1, 1993 to February 16, 1993 when she saw respondent for a total of six office visits. On the occasion of her first office treatment, on or about February 1, 1993, respondent took a history of her present illness, including a chart notation of all her then treating physicians and psychologists, noted her current medical problems and current medications, performed a physical examination and reached an impression that the patient had degenerative lumbar disc disease.

20. On or about February 2, 1993, respondent performed a spinal block using a local anesthetic (Lidocaine

50 mg) and a Schedule II short-term acting narcotic (Fentanyl 50 mcg) which patient M.H. tolerated well and which provided complete pain relief.

21. On or about February 3, 1993, noting that the spinal block performed on the previous day lasted only approximately 2 hours, respondent performed a second spinal block using a local anesthetic (Lidocaine 50 mg) and doubled the Schedule II short-term acting narcotic (Fentanyl 100 mcg) which patient M.H. tolerated well but developed generalized pruritus which required 50 mg's of Benadryl, intramuscularly.

22. On or about February 4, 1993, noting that there was no overall incremental improvement in the patient's pain, respondent performed a diagnostic intravenous Lidocaine infusion, beginning with 50 mg's with an additional 150 mg's for a total dose of 200 mg's. This was followed by a trial prescription for Mexiletine.

23. On or about February 8, 1993 patient M.H. returned to respondent's office. She apparently did not tolerate the Mexiletine and her pain returned to its baseline soon after leaving his office from the previously appointment. It was at this time that respondent started patient M.H. on a Methadone trial, on a p.r.n. basis, prescribing for her one to two 5 mg tablets every 4-12 hours as needed for pain with a total number of 50 tablets prescribed. He discussed titrating the dosage to her needs with her and scheduled a follow-up appointment for one week later having made available to her a total of 250 mg of Methadone during said week.

24. On or about February 16, 1993 returned to respondent's office for what turned out to be her final

visit. She reported having taken two Methadone every four hours with essentially no effect on her pain. Further, she reported to respondent a previous history of street drug use, primarily cocaine. She had not had any cocaine for over a year but it was noted that this could be affecting her tolerance to the Methadone. The chart for this office visit noted that patient M.H. reported that her psychologists were pleased and that she brought with her a note from a psychologist asking respondent to consider the possibility of "Versed Injections". Respondent then issued a new prescription for Methadone, on a p.r.n. basis, prescribing for her three to four 5 mg tablets every 4-6 hours as needed for pain with a total number of 200 tablets prescribed. Respondent thereby made available to her a total of 1000 mg of Methadone. Respondent's treatment plan consisted of increasing her Methadone, re-evaluating her based on the increased dosage of Methadone, have the patient return with imaging scans of her back and consider the possibility of a pump and a Versed block in the future.

25. On or about February 19, 1993, not having contacted her parents during the morning as was her routine and her parents being unable to contact her despite efforts to do so, patient M.H. was found, unconscious, unresponsive and comatose in her apartment by the manager of the apartment building in which she lived. She was rushed, by ambulance, to the emergency room at Humana Hospital in San Leandro where, after having had her stomach lavaged, and laboratory tests performed, she was admitted with a diagnosis of suicide attempt and acute respiratory failure secondary to phenothiazine

(Mellaril) and Methadone overdose and aspiration pneumonia. She was discharged on February 28, 1993.

26. In diagnosing, caring for and treating patient M.H., as alleged in paragraphs 15 through 25, respondent did so in a grossly negligent and/or negligent and/or incompetent manner as follows:

A. Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient M.H. to self administer Methadone, on an as needed basis. Methadone is not prescribed in a p.r.n. manner as was done with patient M.H., but in a stated milligram dose every six or eight hours.

B. Respondent failed to appropriately consider patient M.H.'s relevant recent psychological, including suicidal and street drug abuse medical history, in the manner in which he prescribed Methadone for this patient. Methadone has a variable half life, and does not reach steady state blood levels for as long as five days after dosing is started. Therefore, a patient may not notice the effects of an increase in the methadone level for as long as five days after the dosing. To prescribe Methadone, on a p.r.n. basis, for a patient with M.H.'s recent relevant medical history demonstrates a lack of knowledge or understanding of the pharmacology of Methadone.

C. Respondent caused patient M.H. to undergo, without medical indication or justification, two spinal anesthetics with local anesthetic and narcotic. These procedures were without any diagnostic or therapeutic value and constitute both clearly excessive use of diagnostic and/or treatment procedures and an extreme departure

from the standard of practice among the community of California licensed physicians practicing pain management.

27. Respondent's conduct as alleged in paragraphs 15 through 25, detailing the treatment and professional care provided to patient M.H., constitutes gross negligence and/or repeated negligent acts and/or incompetence and is grounds for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and/or (d).

28. Further, respondent's conduct as alleged in paragraphs 15 through 25 detailing the treatment and professional care provided to patient M.H., constitutes repeated acts of clearly excessive use of diagnostic or treatment procedures (spinal anesthetics) as determined by the standard of the community of licensees in violation of section 725 of the Code subjecting respondent's certificate as a physician and surgeon to discipline for unprofessional conduct pursuant to section 2234 of the Code.

FIFTH CAUSE FOR DISCIPLINARY ACTION

29. At all times relevant hereto, respondent was practicing as a physician and surgeon in Walnut Creek, California doing business as Pain Relief Center and performed the surgical procedure described in this cause for disciplinary action at the Kaiser Permanente Hospital located in Vallejo, California.

30. Beginning on or about February 1, 1990, respondent first saw male patient B.C., who was 37 years old at

said time, at Pain Relief Center in Walnut Creek upon referral from Kaiser Permanente Hospital in Vallejo, California. Patient B.C., in 1987, first began developing lumps on the left side of his neck. A biopsy showed this was due to cat scratch fever with enlargement of the lymph node. Following partial removal of the cysts, first in 1987 and again in 1988 for a recurrent mass, patient B.C. noted pain in the distribution of the trigeminal nerve (chronic trigeminal neuralgia) and was eventually referred to respondent as noted above. Before being referred for a consultation with respondent, a pain specialist, his pain continued unabated and he underwent various tests and treatments in an unsuccessful effort to relieve the pain.

31. At the time of his first office visit with respondent, on February 1, 1990, respondent had been apprised of previous attempts at pain relief which included localized injections at Kaiser Hospital with relief of his symptoms, transiently, but the pain always returned to its original intensity. Using an upper thoracic epidural catheter, respondent performed a diagnostic block at the approximately T1-T2 interspace, injecting patient B.C. with incremental 0.5% Lidocaine. Patient B.C. experienced complete relief of his pain symptoms and respondent recorded the response as being consistent with sympathetic dystrophy. The catheter was left in place to facilitate an injection the following day.

32. Patient B.C. next saw respondent the following day, on February 2, 1990, reporting that the previous day's injection had provided pain relief for approximately 3 1/2 hours and was back to full intensity in 4 hours. Respondent injected areas which on palpation

indicated an underlying somatic or inflammatory component with 1% Lidocaine with DepoMedrol 40 mg total. Following the injections, patient B.C. was completely pain free to palpation and the sympathetic component.

33. Patient B.C. next saw respondent on February 5, 1990 where he reported essentially the same pain relief following the second office visit as occurred after the first block was attempted during the first office visit with no improvement. At this point, rather than attempt any further blocks, respondent referred patient B.C. back to his Ear, Nose and Throat (ENT) physician to have him evaluated for underlying structural problems.

34. Patient B.C. was next seen by respondent on February 8, 1990 when he returned to respondent's office for a diagnostic block prior to examination by his ENT physician. An upper thoracic epidural catheter was passed and he was injected with incremental 0.5% Lidocaine until evidence of sympathetic block was obtained.

35. On or about March 27, 1990 patient B.C. returned to respondent's office following exploratory surgery by his other treating physicians. While a neuroma was found and excised during the surgery, the pain component did not improve. During the office visit, respondent performed a stellate ganglion block with 1% Lidocaine with 10 cc of 5 mg Morphine added. Respondent noted good sympathetic block along with excellent relief of the patient's pain symptoms. After about 1 hour of observation, abdominal pain (epigastric) resolved and the original pain came to about a 50% level in the left neck area.

36. Patient B.C. next saw respondent the following day, on or about March 28, 1990 where he reported having his pain return to its full intensity about three hours after leaving the office the previous day. Respondent decided to repeat the previous day's procedure of a left stellate ganglion block. Once again complete pain relief was attained, however after about 1 hour patient B.C. began to experience his pain once again. At this point respondent repeated the stellate ganglion block using 10 cc of .5% Bupivacaine with another 5 mg of Morphine injected.

37. On or about March 29, 1990, patient B.C. next consulted with respondent reporting that the pain returned about 3 hours after leaving respondent's office the previous day. Respondent noted that it did not appear that patient B.C. obtained good pain relief with stellate ganglion block and assessed him as being a candidate for either stellate ganglionectomy and/or Phenol injection. Respondent decided that prior to resorting to some permanent kind of therapy, such as surgery and cutting of nerves, he would provide patient B.C. with trials of epidural blocks and narcotics for his pain. Respondent then proceeded to insert an epidural catheter in the upper thoracic epidural space, at about the T1-T2 interspace, through a 17 gauge Hustead needle. The catheter was injected with incremental 0.5% Lidocaine until he had complete relief of his pain symptoms. This was followed by an injection with 50 mg of Demerol and 80 mg of DepoMedrol diluted with 10 cc of normal saline. Patient B.C. developed some lightheadedness and was given 2 1/2 mg of Naltrexone which corrected the symptoms and he obtained good pain relief. Respondent provided

patient B.C. with Naltrexone to take home should his symptoms return and scheduled a follow up appointment.

38. On or about April 2, 1990, patient B.C. returned to respondent's office. Patient B.C. reported that he obtained 6 hours of complete relief from the Demerol injection administered during the previous appointment on March 29, 1990 before the pain returned to its original intensity. Respondent then proceeded to provide patient B.C. with a Morphine injection. Respondent placed an upper thoracic epidural catheter at the T1-T2 interspace which he injected with 5 mg of Morphine and 5 cc of 0.5% Lidocaine. Patient B.C. reported obtained about 50% relief of symptoms with this injection over about a half an hour and developed some abdominal cramping. Another 5 mg of Morphine was then injected through the catheter and the catheter flushed with a small amount of 0.5% Lidocaine. Patient B.C. then reported essentially complete relief of his pain symptoms and respondent dispensed Naltrexone, as a prophylactive measure when the patient went home.

39. On or about April 3, 1990, patient B.C. returned to respondent's office and reported having obtained approximately 10 hours of pain relief from the previous day's Morphine injections. Respondent discussed with patient B.C. the alternatives treatment modalities of either a phenol sympathetic block (neurolytic stellate ganglionectomy), surgical sympathectomy (surgical stellate ganglionectomy) or an implanted morphine infusion pump and decided to consult with the patient's other treating physicians as to the options.

40. On April 10, 1990 respondent communicated, in writing with patient B.C.'s primary physician at Kaiser Hospital in Vallejo. In this communication, respondent described the course of treatment, the results and the three options which he discussed with the patient during the last office visit of April 3, 1990. In regards to option #1, a phenol sympathetic block, respondent indicated that he did not feel comfortable in performing same, having had no personal experience with it, in view of the risks involved. Next, respondent discussed option #2, the surgical stellate ganglionectomy, describing same as a reasonable option to pursue. Finally, in regards to option #3, the implanted Morphine infusion pump, respondent opined that it should reliably work for the patient and didn't involve any permanent neurodestructive techniques noting that it was a new technique and the devices are expensive. However, respondent indicated that option #3 should not be considered until the patient had been evaluated by a surgeon or refused the operation or had the operation and have it fail to provide him with adequate relief.

41. Respondent next saw patient B.C. on or about October 2, 1990 after having been evaluated by a physician at the University of California Medical Center at Davis, California. This physician, a neurosurgeon, opined that patient B.C. was a candidate for either a surgical sympathectomy or a Morphine infusion pump. There was disagreement, however, over whether the patient's Kaiser coverage would pay to have the surgery performed by this neurosurgeon outside of a Kaiser facility and patient B.C. returned to the care of respondent. During this office visit respondent performed some Phenol trigger point

therapy by injecting a small amount of 0.5% Marcaine into the scar on the patient's neck from his previous surgeries. The patient obtained good, but not complete pain relief from this procedure. Respondent allowed the medications to soak in the tissues for approximately a one half hour and then repeated the procedure, this time injecting 1 cc of 6% aqueous Phenol solution into the area without any substantial neurologic change prior to leaving the office.

42. Patient B.C. next saw respondent on or about October 8, 1990 and reported having obtained pain relief for approximately 3 to 4 hours from the procedure performed by respondent during the previous office visit. Respondent then treated patient B.C. as he had on the previous office visit, injecting 1 cc of 6% aqueous Phenol solution into the subcutaneous tissues deep into the scar on the left side of the patient's neck.

43. On or about January 25, 1991 respondent notified patient B.C. the he [sic] (respondent) had been called to active duty with Operation Desert Shield and that the Pain Relief Center, where patient B.C. had been consulting with respondent could be forced to close its doors on very short notice. Patient B.C. was advised that respondent would no longer be able to attend to him for ongoing care and advised patient B.C. to consult his primary care physician for ongoing and follow up care.

44. On or about December 6, 1991, at the request of patient B.C. and in order to have his Kaiser medical plan cover the costs associated with the surgery, patient B.C. was admitted to Kaiser Hospital in Vallejo for the attempted insertion of an intrathecal narcotic infusion

pump by respondent. A small incision was made at approximately the T5-T6 interspace and multiple unsuccessful attempts were made, using a 14 gauge epidural needle, to enter the intraspinal space. Respondent then moved one space further cephalad (toward the head) where, once again, multiple unsuccessful attempts were made, using both a 14 and 22 gauge epidural needle, to enter the intraspinal space. Further incision, made to join the two sites and to deepen the incision in order to allow attempts to get below the skin and into the subarachnoid space, via multiple attempts, also proved unsuccessful. Thereafter, respondent attempted entry from various positions, including the midline and to the right of the paramedian approach, without success. On one occasion when respondent felt that he had entered the subarachnoid area, he obtained free flowing, but very bloody, fluid. At this point the patient developed bigeminy (a form of arrhythmia) and the anesthesiologist had to administer Lidocaine in order to return the patient to a normal sinus rhythm. Respondent next attempted to enter the subarachnoid space in the lumbar area, as opposed to the thoracic area, and inserted a 22 gauge needle at approximately the L1-L2 area where he obtained grossly bloody fluid. At this point the attempted procedure was aborted. At no time during the procedure was fluoroscopy used. After the patient was awakened and regained minimal ability to respond in the operating room, he was noted to have poor movement of the right lower extremity and he underwent an emergency CAT scan where it was discovered that he had also sustained a pneumothorax. The patient was transferred, via emergency ambulance, to the Kaiser Hospital in Sacramento

because of the development of the paraplegia where an emergency MRI revealed evidence of a small spinal cord contusion at the thoracic level. Patient B.C. remained hospitalized for 11 days before he was discharged for home nursing care and physical therapy for his paraplegia.

45. In diagnosing, caring for and treating patient B.C. during said time, respondent did so in a grossly negligent and/or negligent and/or incompetent manner as follows:

A. Respondent failed to perform a complete history and physical examination of patient B.C. during the initial patient visit or at any time before embarking on a course of treatment involving numerous invasive procedures.

B. Respondent specifically failed to record a history which included a description of the pain, its location, aggravating and relieving factors, effects on the patient's lifestyle and activities of daily living, a complete past medical history which would include other medications and treatments previously tried and currently in use and a history of alcohol or drug dependence.

C. Respondent specifically failed to perform a physical examination which noted the limitations caused by the pain. Although pain can only be evaluated in subjective terms, objective physical findings are useful to determine if the patient is making progress towards a more functional lifestyle.

D. By failing to perform a complete physical examination which noted the limitations caused by the pain,

respondent could not, and did not, initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment. If the patient shows no improvement in his functional abilities, then a different treatment plan should be instituted.

E. By failing to institute an objective, measurable treatment plan for patient B.C., respondent could not, and did not, evaluate the patient at periodic intervals, using the original history and physical as a baseline.

F. Prior to proceeding with a narcotic infusion pump respondent failed to use other medications trials or treatment modalities, commonly used by pain management physicians for treatment of neuropathic pain such as tricyclic antidepressants, antiseizure medications, antiarrhythmic medications, Capsaicin cream, oral narcotics or physical therapy to improve range of motion and muscle strength and to help evaluate the patient's progress, and psychologic counseling and support if available.

G. Respondent made the diagnosis of sympathetic dystrophy after placing an epidural catheter and injecting 0.5% Lidocaine when the Lidocaine itself could easily give a sensory block and make the diagnosis suspect. Respondent compounded the uncertainty of the diagnosis when he proceeded to perform stellate ganglion blocks, which would have been useful in determining whether this was a sympathetic dystrophy, however he included Morphine in the solution each time. Morphine would be useful to include as a therapeutic measure, but clouds the picture when used in a diagnostic stellate ganglion block and makes the test of no value.

H. Respondent injected local anesthetic, epidural narcotics through an epidural catheter. There was no clear indication for using steroids in this condition. Injecting narcotics and then discharging the patient, who had no history of having been prescribed or administered high doses of oral or intravenous narcotics and without appropriate respiratory monitoring, is an extreme departure from the standard of practice among the community of California practicing physicians.

I. Injecting narcotics with local anesthetics, as respondent did in this case, would not be a diagnostic test that would be useful for determining whether an intrathecal narcotic infusion pump would be beneficial to the patient.

J. Respondent's decision to attempt to place an intrathecal narcotic pump was premature given the lack of more conservative measures.

K. Respondent's decision to place the infusion catheter at the thoracic level indicates a lack of knowledge, skill or training to, with safety, perform his professional medical obligations. Respondent demonstrated a lack of knowledge of both how the catheter is inserted and how intrathecal Morphine circulates in the cerebrospinal fluid. Intrathecal Morphine is hydrophilic, meaning that it will circulate freely in the cerebrospinal fluid. Narcotic infused at the lumbar level, where it is much safer to place the catheter, would achieve the same concentration at the thoracic level as a catheter placed at that level. Furthermore, the catheters are designed to be threaded from the lumbar region below the spinal cord upwards under Fluoroscopy, so that if it was necessary to place a

catheter at the thoracic level, it should have been done from an insertion point at the lumbar level. Respondent attempted to place the catheter through a thoracic entrance site and failed to use Fluoroscopy.

L. Respondent attempted the procedure, at the thoracic site, with the patient under general anesthetic.

46. Respondent's conduct as alleged in paragraphs 29 through 45, detailing the treatment and professional care provided to patient B.C., of failing to perform a complete history and physical before embarking on a course of invasive treatment; of performing confusing nerve blocks which did not adhere to a logical treatment plan which were, at times, dangerous when performed in an outpatient setting; of proceeding to attempt insertion of a narcotic infusion pump without exploring other medication or other more conservative modalities, and the attempted placement of an intrathecal narcotic infusion pump under general anesthesia, without Fluoroscopy, at the thoracic level constitutes gross negligence and/or repeated negligent acts and/or incompetence and is grounds for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and/or (d).

47. Pursuant to Business and Professions Code section 125.3, in any order issued in resolution of a disciplinary proceeding, the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

WHEREFORE, complainant requests that the Board hold a hearing on the matters hereinabove, as well as the

matters alleged in the original accusation presently on file against respondent, and after that hearing issue an order;

1.) Suspending or revoking physician's surgeon's certificate No G 39260, heretofore issued to Respondent Franklin Jerome Day, M.D.;

2.) Granting the Medical Board of California its reasonable costs of investigation and prosecution of this case; and

3.) Taking such other and further action as is deemed just and proper.

Dated: February 16, 1995

/s/ Alfredo Terrazas, RAG for
DIXON ARNETT
Executive Director
Medical Board of California
State of California
Complainant

DANIEL E. LUNGREN, Attorney General
of the State of California
ALFREDO TERRAZAS, STATE BAR No. 78403
Deputy Attorney General
2101 Webster Street, 12th Floor
Oakland, CA 94612-3049
Telephone: (510) 286-3795
FAX (510) 286-4020
Attorneys for Complainant

BEFORE THE MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Franklin Jerome Day, M.D. P. O. Box 306 San Leandro, California 94577 Certificate No. G-39260 Respondent.	No. D-5613 SECOND SUPPLEMENTAL ACCUSATION

DOUG LAUE, complainant herein charges and alleges as follows:

1. He is the Acting Executive Director of the Medical Board of California, State of California (hereinafter "the Board") and makes these additional charges and allegations to be added to the charges and allegations contained *In the Matter of the Accusation Against: FRANKLIN JEROME DAY, M.D.*, filed on February 2, 1994, and to the charges and allegations contained *In the Matter of the*

First Supplemental Accusation Against: FRANKLIN JEROME DAY, M.D., filed on February 16, 1995, solely in his official capacity.

SIXTH CAUSE FOR DISCIPLINARY ACTION

2. At all times relevant hereto regarding female patient J.W., respondent was practicing as a physician and surgeon in Walnut Creek and San Leandro, California doing business as Pain Relief Center.

3. Beginning on or about August 28, 1986, respondent first saw female patient J.W., d.o.b. 2/22/52, a then 34 year old patient who was complaining of chronic, acute and recurrent pain in her left foot and leg. The patient had a history of a falling accident in September of 1979, which resulted in an injury to her left knee. She subsequently had numerous surgeries to that knee. After her second surgery, the patient began complaining of numbness in her left knee which gradually progressed to a burning pain with a hypersensitivity of the skin in her left leg. She eventually had a surgical fusion of her left knee joint, reportedly as an attempt at pain control. Respondent's notation for this first office visit reads, in relevant part, as follows:

> "She is a 32 (sic) year old female who has a long history of a sympathetic dystrophy of the left leg. This has been well evaluated and aggressively treated in the past. She has received numerous sympathetic blocks in the past. These resulted in relief of the pain in the leg, but she has never gotten long term relief from these injections. She has also received intravenous

regional Reserpine with relief of the pain, but again, no long term relief.

She has had epidural steroids in the past, and this has not given her any long term relief. She is a good candidate for a neurolytic injection, but before I do that, I need to document for myself that she does not receive relief from a series of local anesthetic injections, and that she can get good relief with a good sympathetic block."

4. Thereafter, beginning on or about September 2, 1986 began a course of care and treatment by respondent, and his subordinate staff at the Pain Relief Center at Walnut Creek, where he prescribed, in increasing amounts, powerful narcotics, without any adjunctive physical therapy or medications. At the inception of pain medication treatment by respondent and his associates, patient J.W. was provided treatment consisting of the insertion of an epidural catheter with daily nerve blocks for one week via injection of 0.5% Lidocaine with DepoMedrol. She had brief relief with each block. She was then started on Methadone and Minipres.

5. On September 12, 1986 a decision was made to proceed with further epidural sympathetic nerve blocks. She underwent epidural sympathetic blocks frequently, intermittently mixed with DepoMedrol, between September 2, 1986 and November 7, 1986. During this period of time she was switched from Damason P to Methadone. The Methadone was prescribed on a p.r.n. (as needed) basis and the only restraint on the Methadone was whether pain relief was achieved. Notations made during this time that the patient was also seeing a psychiatrist.

6. In October of 1986, Soma 350 mg t.i.d. (three times per day) was added to the Methadone. On October 28, 1986 it was noted by respondent that:

> "She seems to feel that [Soma] helps. She also asked for some more Methadone. I prescribed 100 tablets for her 6 days ago. She states that she takes on the average, 10 per day (Methadone) but she doesn't keep that close track of them. Looking back, her needs have been about 14 per day. This is a significantly large amount of Methadone although she has been on narcotics for a very long time and has obviously developed a tolerance to them. We are obviously not going to be able to change this until we get control of her pain and I feel we are moving in that direction."

7. On or about November 12, 1986 a neurolytic sympathetic block was recommended by respondent. In the same note, respondent commented that an intravenous regional sympthetic block apparently using Reserpine that gave her about one week of relief.

8. Sometime during early 1987 patient J.W. underwent another surgical leg procedure, a sympathicectomy to the left leg at Stanford Hospital. Respondent then did not see patient J.W. again until August 6, 1987 when he noted the surgical procedure and commented that there had been some improvement in her pain symptoms, but certainly not a substantial or complete relief. The left leg remained warm, and she was able to "cut down substantially on her amount of pain medication." Two options were presented to the patient by respondent during this office visit; spinal cord stimulation or epidural narcotic injection. On August 6, 1987 a lumbar epidural catheter

was placed and the patient began receiving injections of narcotics as an outpatient through the catheter. On August 11, 1987 respondent taught patient J.W. to self inject narcotic through the catheter. Between August 6, 1987 and May 6, 1988 patient J.W. underwent numerous DuPen epidural catheter placements and continued to self inject narcotics.

9. On March 17, 1988, a lumbar epidural catheter was placed, however, it was placed subarachnoid rather than epidurally. The chart note for March 18, 1988 states that:

> "She is getting excellent relief with the subarachnoid injections and feels that the pain relief is even more profound that she gets with the epidural injections. In view of this response, we will leave the catheter in place and she will inject that and we will consider very early next week for changing her to a more permanent subarachnoid catheter."

10. On March 23, 1988 the chart noted that patient J.W. was having "persistent leakage of CSF, out of the catheter that was placed the other day". Respondent noted that she was getting ineffective pain relief with her injections, probably because of loss of fluid and that she was not feeling well secondary to withdrawal symptoms associated with persistent spinal fluid leakage. It was then decided to remove the subarachnoid catheter and to place a midlumbar epidural catheter.

11. Between March 23, 1988 and May 6, 1988 patient J.W. experienced multiple problems with both temporary and permanent epidural catheters placed by respondent including headaches, marked changes in mental status

and poor functioning of the epidural catheter tip because in was not correctly placed in the epidural space.

12. On April 19, 1988 patient J.W. was admitted to Los Medanos Community Hospital and further work-up revealed her to have meningitis. On this same date, respondent infiltrated the area of the previous back incisions with local anesthesia and the temporary catheter was removed. Respondent then proceeded to reinstall the previously removed Davol silicone epidural catheter.

13. On May 8, 1988 patient J.W. was re-admitted at Los Medanos Community Hospital, on an emergency basis and on the recommendation of the Infectious Disease Specialist, for treatment of a reoccurrence of meningitis. At the time of her admission, patient J.W. had a fever greater than 101, white blood cell count of greater that 15,000 with a left shift and was complaining of a stiff neck and headache.

14. On or about June 1, 1988 at Los Medanos Community Hospital respondent, in the operating room, placed a percutaneous DuPen long term catheter as well as a permanent subcutaneous port for her. Thereafter, narcotic injection resumed. On or about June 13, 1988, after the patient complained that the catheter had stopped working, an x-ray showed that the catheter had backed out of the epidural space and on July 5, 1988 respondent removed the non-functioning catheter. Patient J.W. was started on Roxanol, also known as oral Morphine, and this medication was continued until a neurosurgeon could place a permanent indwelling catheter into the epidural space so that she could use a pump to instill narcotics.

15. Sometime between August 5 and August 23, 1988, patient J.W. had a permanent indwelling DuPen catheter and Davol subcutaneous injection port placed by a neurosurgeon at the county hospital.

16. On August 23, 1988 patient J.W. returned to respondent's office where respondent provided her with her first injection into the newly installed port and provided her with a prescription for 25 gauge needles and Catapres to help her with withdrawal. On August 26, 1988 the patient reported that when she injected her port that fluid came out of the skin and that she was not obtaining good pain relief. Upon examination, respondent assessed that fluid was leaking back along the catheter path and not staying in the epidural space.

17. Respondent continued to see patient J.W., intermittently, until January 25, 1991. Throughout the chart there are notations that the patient was under-reporting her use of medication, including the theft of her purse resulting in the loss of 100 Roxanol pills on April 6, 1989, and also returning early for refills. There are no notations as to pain level, activity level or side effects of the treatment with oral and injectable narcotics. The chart entry for January 25, 1991, the last date on which respondent saw patient J.W. states, in pertinent part, that "we really haven't done a single shot spinal block to assess dosage so I felt that we should do that one time prior to placing the pump just to ensure that we could have a good starting dose on her." Whereupon, lmg of preservative-free Morphine was injected intrathecally and she was discharged home.

18. In diagnosing, caring for and treating patient J.W. during said time, respondent acting either alone or in supervision of those subordinate to him did so in a grossly negligent and/or negligent and/or incompetent manner as follows:

A. Respondent failed to perform a complete history and physical examination of patient M.G. during the initial patient visit.

B. Respondent specifically failed to record a history which included a description of the pain, its location, aggravating and relieving factors, effects on the patient's lifestyle and activities of daily living, a complete past medical history which would include other medications and treatments previously tried and currently in use and a history of alcohol or drug dependence.

C. Respondent specifically failed to perform a physical examination, including other joints in the leg, which noted the limitations caused by the pain. Although pain can only be evaluated in subjective terms, objective physical findings are useful to determine if the patient is making progress towards a more functional lifestyle.

D. By failing to perform a complete physical examination which noted the limitations caused by the pain, respondent could not, and did not, initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment. If the patient shows no improvement in functional abilities, then a different treatment plan should be instituted.

E. By failing to institute an objective, measurable treatment plan for patient J.W., respondent could not, and

did not, evaluate the patient at periodic intervals, using the original history and physical as a baseline.

F. Respondent failed to use other medications or treatment modalities, commonly used by pain management physicians for treatment of neuropathic pain such as tricyclic antidepressant, selective serotonin re-uptake inhibitors, antiseizure medications, anti-arrhythmics, Capsaicin Cream, or physical therapy to improve range of motion and muscle strength and to help evaluate the patient's progress, and psychologic counseling and support if available.

G. Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient J.W. to self administer narcotics, on an as needed basis, in the epidural and intrathecal catheters. Allowing the patient to self inject entails a high risk of infection in the epidural or intrathecal space, which can lead to permanent neurologic damage or even death. The risk is well recognized when allowing cancer patients to self inject, but is not acceptable with non-cancer patients.

H. Respondent incompetently and/or negligently and/or grossly negligently used deposteriods in the epidural space. There is no indication that use of steroids given epidurally has any affect [sic] on RSD. In addition, if respondent understood the mechanism of action of deposteroids, in that they continue to exert their effect for 2-3 weeks, he would have known that there was no indication to inject the steroids daily.

I. In spite of the fact that there was no sustained response to the epidural or sympathetic nerve blocks, respondent repeated them over a period of months.

Respondent should have known that if the injections were continued, each injection should have provided a more long lasting pain relief period. If this does not occur, then the patient is not responding to the nerve blocks and they should be abandoned, or a neurolytic block performed.

J. Respondent prescribed numerous narcotics without evaluating the patient's response other than her subjective report of pain relief. She continued to rapidly escalate the dose and not keep detailed accounts of the medication that she was using. Without any objective improvement in her pain, and with the massive escalation in narcotic usage from Damason P to Methadone and Roxanol, the continuing use of these narcotics was contra-indicated.

K. Respondent failed to investigate other specific treatments which may have been effective for the patient. In his note of November 12, 1986, he stated that a Reserpine intravenous regional block gave her one week's worth of relief. He should have repeated the intravenous regional block to see if repeated regional blocks could have provided more sustained relief. This is particularly true since he was obtaining less than one day of pain relief from injections of the epidural catheter and considering more invasive and destructive therapies. Similarly, on August 6, 1987 respondent offered the patient the option of spinal cord stimulation versus epidural narcotics. On August 10, 1987 he noted "patient can't decide which technique she would like to try." On August 17, 1987 he noted "she does not seem interested in spinal cord stimulation." However, no discussion was undertaken. Spinal cord stimulation is routinely used for RSD

and is considered safer, more reliable, less costly, and more effective than narcotics alone.

L. Respondent incompetently and/or negligently and/or grossly negligently continued to repeatedly place temporary, as well as "permanent", epidural catheters, despite mechanical problems with the catheters and despite the fact that the patient never had any evidence of sustained pain relief with the catheters. He also inserted the catheters in a non-sterile environment, when such are routinely placed in surgery centers, and without standards in place for peer review or input.

M. Respondent incompetently and/or negligently and/or grossly negligently injected epidural and intrathecal narcotics and then discharged the patient home. Epidural or intrathecal narcotics are known to cause severe respiratory depression and patients administered such narcotics must be monitored for, at minimum, the first 24 hours following the injection.

N. On the final office visit to respondent's office, he performed a spinal puncture on patient J.W. to inject Norphine for evaluation of a starting dose for intrathecal narcotic infusion if a pump were placed. Since respondent had already made the decision that epidural and intrathecal narcotics had been useful in the past, this injection of Morphine had no clear medical indication and was therefore a clearly excessive use of a diagnostic procedure.

19. Respondent's conduct as alleged in paragraphs 2 through 18, detailing the treatment and professional care provided to patient J.W., constitutes gross negligence and/or repeated negligent acts and/or incompetence and

is grounds for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and/or (d).

20. Further, respondent's conduct as alleged in paragraph 17, detailing the treatment and professional care provided to patient J.W. on the occasion of her final office visit on January 25, 1991 where she received an injection of Morphine for evaluation of a starting dose for intrathecal narcotic infusion pump purposes, constitutes repeated acts of clearly excessive prescribing or use of treatments as determined by the standard of the community of licensees in violation of section 725 of the Code subjecting respondent's certificate as a physician and surgeon to discipline for unprofessional conduct pursuant to section 2234 of the Code.

SEVENTH CAUSE FOR DISCIPLINARY ACTION

21. At all times relevant hereto, respondent was practicing as a physician and surgeon in Walnut Creek, California doing business as Pain Relief Center.

22. Beginning on or about November 30, 1987, respondent first evaluated and began treating female patient A.C., d.o.b. 10/8/53, who was 34 years old at said time, for complaints of severe recalcitrant low back pain with a radicular component. The patient was traumatized from her involvement in an injury where, on or about August 10, 1987, while assisting respondent place an orthopedic knee brace on an elderly female patient, the patient fell on top of A.C. while she was in the squatting position. At the time, patient A.C. was working as an orthotic fitter for Doc's Pharmacy. The original diagnosis

for the injury was a lumbar strain and was treated conservatively with rest and anti-inflammatories by another physician. Both plain films and a Computerized Tomography (CT) of the spine were negative for any acute processes or disc herniation. However, degenerative changes (desiccation) were noted in the L1/2 and L5/S1 discs on a subsequent Magnetic Resolution Imaging (MRI) scan of the lumbar spine performed on January 6, 1988. After several weeks her back pain complaints remained sever [sic], even though she tried to return to work. Her care was then assumed by another physician with no change in the management of her muscle spasms and pain, whereupon, she first went to respondent for care.

23. Respondent's initial evaluation of the patient, performed on November 30, 1987, noted that the "patient was currently taking Vicodin 1-2 p.r.n. for pain" without specifying how long or how much of the narcotic, or to what extent it covered her pain. Respondent's diagnostic impression was that the patient had a "ligamentous strain of the lumbar spine", and possibly a "problem" in her sacro-iliac joint, however there is no record of a positive "Gaenslen's sign" for S-I joint problems. He also noted that a recently performed epidural steroid injection had caused increased back pain. The anesthesiologist noted as having performed the injection was not contacted, although respondent indicated that from the patient's description, she couldn't have received an epidural injection. His plan was to immediately perform a differential epidural injection of steroids and local anesthetic to "separate the back from the sacro-iliac component of her pain". During this initial office visit, an epidural injection

was attempted and was unsuccessful due to the patient's adverse reaction, (CNS symptoms including some twitching, hypertension and tachycardia), to either incremental 0.5% Lidocaine or 10cc of 2% Nesacaine, which respondent attributed to an undetected catheter placement into an epidural vein(s).

24. Respondent next saw patient A.C. the following day, December 1, 1987, when he repeated his attempt at a differential epidural using, again, incremental 0.5% Lidocaine whereupon the patient became hypertensive and shaky requiring two (5mg) doses of Valium, which could have, and most likely did, cloud subsequent observations. Respondent noted that the patient appeared to be susceptible to local anesthetic toxicity. The patient's feet became warm, but her pain was unaffected and respondent concluded that the pain was not sympathetically mediated. Whereupon, respondent proceeded to inject DepoMedrol 80mg followed by 50mg of Demerol. Respondent then noted that the patient's pain relief was complete and she slept for about two hours before leaving the office.

25. Respondent next saw patient A.C [sic] two days later, on December 3, 1987, when he placed another midlumbar epidural catheter and injected 5mg of Morphine (DuraMorph). Although it is not noted in the record as to how long respondent waited, this injection did not completely relieve the patient's pain. Respondent then proceeded with another 5mg's of Morphine which only produced partial relieve [sic] of her pain, however, for some unexplained reason, respondent then proceeded to inject 5 cc's of 1% Lidocaine. Following this injection the patient developed involuntary twitching as well as

marked itching and nausea. The patient was then provided with IM Narcan. Even so, the patient was sent home.

26. On December 10, 1987 patient A.C. returned to respondent's office where the chart note states that "[A.C.] comes in desiring a therapeutic injection to help relieve her pain." Respondent then placed another mid-lumbar epidural catheter and injected in 5mg increments, 10mg of Morphine (DuraMorph). The chart notes that the patient had "only mild central effects", (read "mild CNS effects"), which he treated with 0.4 mg of Narcan. He then left the catheter in place for further injections should she desire them in the near future, and the patient went home.

27. Respondent next saw patient A.C. the following day, December 11, 1987 when she reported 20 hours of 60% relief of her pain. He injected 10mg of Morphine (DuraMorph) with little or no relief and then proceeded to replace the epidural catheter. Thereafter, respondent proceeded to inject an additional 10 mg of Morphine (DuraMorph).

28. Respondent next saw patient A.C. three days later, on December 14, 1987, where the record again shows a repetition of events; i.e.; catheter injected with 10 mg Morphine (DuraMorph) without pain relief, catheter replaced and an additional 10 mg of Morphine (DuraMorph) injected. The patient developed nausea which was treated with Narcan, and then discharged home. Later that same day she was admitted to a nearby hospital, John Muir Medical Center, for a drug reaction

with symptoms of vomiting, nausea, rash, itching, bladder distention, etc. According to the hospital records, respondent did not have admitting privileges at the hospital and was not available for consultation at the time of her Emergency Room evaluation. The patient was admitted to the hospital for observation of the drug reaction, with an admission impression of excessive epidural morphine, and was discharged on December 16, 1987. There are no notations of this episode in respondent's records.

29. Respondent next saw patient A.C. on December 21, 1987 and while no notation mentioned the hospitalization induced by the prior appointment's treatment, respondent removed the catheter and started the patient on Methadone 5mg pills which the patient was to titrate to see if she could obtain a better pain solution than the Vicodin she was then taking.

30. Respondent's medical records next indicate, without indicating where, that from January 7, 1988 to February 4, 1988 patient A.C. tried various other methods of pain management including biofeedback and hypnosis without providing details as to success or lack thereof. There is a note in the chart, dated March 23, 1988 that the patient was seen during this time period by a Marriage, Family and Child Counselor who saw the patient since early February of the same year, on a weekly basis, for hypnosis and supportive counseling.

31. Patient A.C. was next seen in respondent's office on February 12, 1988 when she was seen by respondent's wife, also a physician, where the chart notes indicate that the patient was taking Methadone (Dolophine) 10 mg

every four hours while awake for pain, Vistaril for anxiety and Soma as a muscle relaxant, all prescribed by respondent. At this time the patient was also started, for the first time, on an anti-depressant medication, Deseryl 50mg hs (at the hour of sleep).

32. Approximately two months later, on April 5, 1988, patient A.C. was next seen by respondent complaining of poor pain relief with Methadone, asking respondent to try the epidural Morphine again. Respondent acquiesced with the patient's wishes and placed an upper lumbar epidural catheter and administered two 5mg boluses of Morphine obtaining no more than a transient "whoop-dee-do feeling" without relief of pain. She complained of some light-headedness and developed very mild twitching. She was discharged feeling better and was provided with Narcan, in a syringe and without indicating the amount, which was given to her "attendant" son.

33. The patient was seen by respondent the next day, April 6, 1988 when he injected her through the epidural catheter with 15 mg of Morphine. The note concludes with the entry, "We taught her some self-injection techniques, and she is going to go home and practice drawing up the medicines so that we can get her on a self-injection regimen".

34. Thereafter on April 7 and 8, 1988 patient A.C. visited respondent's office where respondent further instructed and witnessed the patient self-inject 15 mg of Morphine on each occasion. On Monday April 11, 1988 the patient again returned to respondent's office where she reported excellent pain relief over the weekend from

her self injections, getting 12-14 hours of complete relief with 15 mg of Morphine per day. However, the patient had a low grade fever, tenderness around the catheter site with a purulent discharge also noted. The catheter was cleaned with peroxide and betadine and she was placed on antibiotics (Dicloxicillin, 500 mg 4 times per day). The patient was quite emphatic that she did not want the catheter removed.

35. The patient was next seen by respondent two days later, on April 13, 1988, when he noted that the tenderness around the catheter site had gone away and that she was recovering from generalized viral infection and that she had now started giving herself a second injection at night, describing this second injection only in the terms of "a smaller injection". Respondent then charts that he will follow-up with the patient on an "as needed basis".

36. The patient was next evaluated on April 18, 1988 when it was noted that she complained of continuing back pain and a headache. Her temperature was 100 degrees, redness and tenderness at the catheter site was recorded and the catheter was left in place despite respondent's assessment to rule out systemic infection.

37. The patient was next seen on April 25, 1988 when tenderness was again noted around the catheter site, her temperature was recorded at 99.8 degrees, the patient complained of a headache and noted that the injections were less effective. The catheter was pulled and the patient was told to use Methadone until her temperature was back to normal.

38. On April 27, 1988 a DuPen long-term epidural catheter was placed in the patient at approximately the L1-2 interspace.

39. From May 5, 1988 to September 6, 1988, patient A.C. had the following significant medical care and treatment from respondent:

> May 5, 1988 – The catheter was not working well and it was thought to be disconnected. X-ray with dye showed the catheter to be in the epidural space and the patient was injected with 15 mg of Morphine.
>
> May 12, 1988 – The patient complained of poor pain relief and nausea following larger doses, without any notation of how much narcotic was used or given. Narcan was given without any notation as to what amount was given.
>
> May 20, 1988 – Injections do not give relief and fluid was observed coming out at the catheter site. The Dupen catheter was replaced, although it appears that this was done in respondent's office.
>
> May 27, 1988 – Visit for suture removal. Patient noted to have lost 15 pounds in one week. Chart says, "Follow-up when [patient has] lost another 20 pounds".
>
> June 8, 1988 – Catheter stopped working the day before with fluids coming out with injections. In his office, respondent then removed the distal portion of the catheter and it was removed and saved. The same internal part of the catheter system was then reused and a new external part attached.
>
> June 9, 1988 – A catheter connector failure was noted due to separation at the point where the internal and external catheters connect. Respondent repaired the connection in his office.

June 17, 1988 – Injectate completely leaking out of catheter site with poor pain relief. The patient feels like she is in withdrawal. The catheter was injected with 15 mg Morphine while in the sitting position with no leakage.

July 25, 1988 – Patient A.C. complains that the catheter has been very painful to inject. Continues to lose weight, now approximately 35 pounds. Started on trial of antibiotics.

August 1, 1988 – Leakage at catheter site again. Catheter revised, in office, once again using same internal part which was reinserted.

August 8, 1988 – Catheter continues to leak. Catheter injected with fluid and air. Fluid leaked back easily and air bubbles felt distal to catheter connector site. X-ray showed catheter to be in probable good position. Once again in his office, respondent performed a surgical procedure on the patient, this time the ordinary epidural portion of the DuPen long term catheter was placed internally and connected to the external catheter.

August 15, 1988 – Patient A.C. complains of pain on injection of catheter, but good pain relief. Catheter plug was wiped with betadine solution and 20 mg DepoMedrol injected in order to keep catheter open.

August 24, 1988 – Patient reported excellent results from steroid injection of 8/15/88, reducing pain with injection and lasting almost 10 days. Requests repeat. 20 mg DepoMedrol injected.

September 6, 1988 – Patient reports injections becoming very painful for her again. Got good improvement in these symptoms for several weeks after injection of steroids. Desires repeat. Still losing weight and problem may be catheter migration and if

continue to have problem may need to move. 20mg DepoMedrol injected.

40. On September 9, 1988 patient A.C. was seen at the Emergency Room of a nearby hospital, Mt. Diablo Hospital Medical Center, for a drug reaction with symptoms of extreme shortness of breath and coughing with wheezing after injection of Morphine. According to the hospital records, the patient went to the fire station and had some resolution of the symptoms on Oxygen before being brought to the emergency room. Due to the patient's history of "allergy" to epinephrine, she was given an Alupent treatment and after observation for an hour her symptoms seemed to resolve. After consultation by telephone with respondent, the patient was discharged home with an antihistamine and told to hold the Morphine and follow up with Dr. Day the following Monday. There are no notations of this episode in respondent's records.

41. The patient was next seen by respondent on September 21, 1988 when she complained that pain with injection had returned which required her to inject herself over two hours. Respondent inspected the catheter site, found no evidence of infection, wiped the catheter plug with betadine solution and injected 20mg DepoMedrol.

42. On October 5, 1988 patient A.C. complained to respondent of mild difficulty breathing after her injections which was relived with antihistamines. She also complained of painful injections. Respondent treated with an epidural dose of Demerol, without recording the dose. Later that evening, the patient was seen at the emergency room of a nearby hospital, Los Medanos Community Hospital, complaining of severe back pain, radiating into her left hip following the injection of Demerol earlier in the day at respondent's office. The emergency

room physician commented that the patient indicated that the catheter was touching a nerve and that it had a history of migrating. She was given Valium IV and very slowly injected with Lidocaine, via the epidural catheter, and discharged after several hours, ambulatory.

43. The following day, October 6, 1988 the patient was seen by respondent, in his office, still in severe pain but also running a fever. A CBC was drawn and her WBC was elevated (13,000) with a left shift. Tenderness over the spine was noted and respondent assessed an epidural infection, but not an abscess. The epidural portion of the catheter was removed and sent for gram stain and culture. The pain, however, did not subside with removal of the catheter and it took 45mg of Morphine with additional Droperidol, versed, to caused her to rest but did not completely relieve the pain. Respondent then proceeded to remove the epidural portion of the Dupen long term catheter, noting that the catheter connector site was covered with a thick fibrous sheath complicating its identification. She was unable to ride in a private vehicle because of her medicated state so transport to the hospital was by ambulance.

44. Patient A.C. was admitted to Los Medanos Community Hospital on October 6, 1988 and discharged on October 13, 1988. She was admitted with tenderness at the catheter site, an elevated WBC (11,000 on admission), low grade temperature and the initial assessment was that of a parameningeal versus superficial cellulitic infection. She did not complain of headache or of stiffness of the neck. The spinal fluid was normal. She was treated with intravenous and later oral antibiotics and her discharge from the hospital was delayed because of severe

back pain requiring very large doses of intravenous Morphine which were managed by respondent. CT scan of the back and lumbar spine X-rays were done while she was hospitalized and the CT scan of the lumbar spine was read as normal. At discharge she was ambulatory and stated that she was unable to tolerate a decrease in her Morphine dosage, which the treating physician noted as "substantial". She was discharged with Ceclor, 250 mg twice a day for four more days and Methadone, 10 mg, three every four hours for pain. The discharge diagnosis was 1) Cellulitis at the site of the epidural catheter; 2) Meningitis, rule out; 3) Chronic back pain and 4) Chronic narcotic use.

45. Respondent next saw patient A.C. in his office on October 17, 1988. He charted that her pain was only under partial control with 30 mg Methadone, every four hours and noted slow mentation as a probable drug effect. To combat this, respondent then prescribed 5mg Amphetamine twice a day as a trial to see if he could decrease the Methadone or, if ineffective, then increase it to 40mg, every four hours.

46. On November 2, 1988 respondent removed the external portion of the DuPen long term catheter and noted that her pain relief was not very good on the oral medications. The chart also notes the expectation on the part of the patient, as well as respondent, that an orthopedic surgeon would perform a lumbar spine fusion operation if the patient would lose another 30 pounds.

47. Respondent next saw patient A.C. on November 29, 1988 when she informed him that the Methadone was not working well. Respondent noted that she was not

taking as much of the narcotic as he had ordered, only taking 2-3 pills every 4 hours, and increased the narcotic intake to 3-4 pills every four hours.

48. Respondent then saw patient A.C. for what appears the last visit with him on December 13, 1988 when he refilled her medication prescriptions. Thereafter, over approximately the next twelve months, patient A.C. was seen at Pain Relief Center in Walnut Creek, California by respondent's physician wife, Dahlis M. Day, M.D., who attempted, with minimal success, to taper the patient off her dependence of Methadone, starting with one less tablet per day per week.

49. In diagnosing, caring for and treating patient A.C., as alleged in paragraphs 21 through 48, respondent did so in a grossly negligent and/or negligent and/or incompetent manner as follows:

A. Respondent specifically failed, during the patient's first office visit, to record a history which included a description of the pain, its location, aggravating and relieving factors, effects on the patient's lifestyle and activities of daily living, a complete past medical history which would include other medications and treatments previously tried and currently in use and a history of alcohol or drug dependence. While he did record that "the patient was currently taking Vicodin 1-2 p.r.n. for pain", he did not specify how long or how much of the narcotic she was taking or to what extent it covered her pain. This is essential data for pain management. In regards to other treatments, his records indicate that from the patient's description, "she couldn't have received an earlier epidural injection", however no notation indicates

that he even attempted to contact the anesthesiologist who performed the earlier procedure, which should have been done. (See paragraph 23 hereinabove). Further, during the initial appointment, respondent performed a differential epidural injection of steroids and local anesthetic to "separate the back from the sacro-iliac component of her pain". Such a separation is not possible using epidural local anesthetics. Rather, the appropriate procedure would have been to plan a sacro-iliac joint injection to determine if that was the source of her pain or perform a "correct" epidural steroid injection to assess its effect on her back pain. Finally, the epidural attempt was unsuccessful because the patient had an adverse reaction to either Lidocaine or Nesacaine, which respondent discovered was due to an undetected catheter placement into an epidural vein(s). Physicians should *always aspirate first before injecting* into an epidural catheter, and the records do not indicate whether respondent did aspirate.

B. By failing to perform a complete physical examination which noted the limitations caused by the pain, respondent could not, and did not, initiate a treatment plan noting what objective factors would be used to evaluate the success of the treatment. If the patient shows no improvement in functional abilities, then a different treatment plan should be instituted.

C. By failing to institute an objective, measurable treatment plan for patient A.C., respondent could not, and did not, evaluate the patient at periodic intervals, using the original history and physical as a baseline.

D. During the second office visit of December 1, 1987, (See paragraph 24 hereinabove), when respondent

repeated his attempt at a differential epidural, if the patient's responses were not clouded by the Valium which he gave her, then his conclusion that the pain was sympathetic was correct, even though this was a relatively minor issue at the time. If his purpose really was to determine the effect of steroids (DepoMedrol), then he should have waited the normal 24 to 48 hours to assess the result. Further, injecting a narcotic (Demerol) into the epidural space at the same time as the steroids only confused the pain assessment.

E. During the subsequent office visits where respondent would place, replace, move and inject into epidural catheters, the patient clearly showed signs of various "adverse" reactions to narcotics and local anesthetics; i.e., twitching, breathing problems, rash, etc. When on December 3, 1987, during only the third office visit respondent injected 10 mg of Morphine into the epidural space, this was a risky and large dose for the first time and it usually requires that the patient be observed for 24 hours. Further, injecting epidural Lidocaine in a patient known to have adverse reactions to epidural local anesthetics was not indicated and was, in fact, strongly contra-indicated.

F. Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or allowed patient A.C. to self administer Morphine and, later, oral Methadone, on an as needed basis. Methadone is not prescribed in a p.r.n. manner as was done with patient A.C., but in a stated milligram dose every six or eight hours. Further, he proceeded in this fashion without obtaining any prior psychological evaluation which might have predicted her response to narcotics. Next, he

proceeded to administer and prescribe these powerful narcotics before ruling out other available treatment modalities including counseling, anti-depressant medication, combinations of analgesics and anti-depressants, graduated physical therapy and, most important, he failed to establish clear guidelines for the use of potent drugs, such as a narcotic contract. While it is true that respondent did try some of these treatment modalities during his care and treatment of patient A.C., these were all tried after he had turned to powerful narcotics and never did he attempt to treat with a plan that didn't include an overwhelming component of narcotic medications. In fact the record is replete with notations that patient A.C. was becoming addicted and/or dependent on the narcotics. (See paragraph 26 hereinabove, regarding the office visit of December 10, 1987, which charts the "mild effect of 10 mg of epidural Morphine", which should have been underscored to all involved as a clear warning). Also, the next day, December 11, 1987, (See paragraph 27 hereinabove), the patient now needed 20 mg of Morphine over a short period of time to achieve "good pain relief". Finally, see also paragraph 35 hereinabove, regarding the office visit of April 13, 1988, where the patient was noted as having started the practice of "giving herself a second injection at night" clearly demonstrating that the patient was the one in control of the narcotics and that respondent had abdicated and lost total control of the situation. Respondent no longer knew how much Morphine she was self injecting or even whether she was providing Morphine to anyone else.

G. Respondent incompetently and/or negligently and/or grossly negligently taught, encouraged and/or

allowed patient A.C. to self administer narcotics, on an as needed basis, in the epidural and intrathecal catheters. Allowing the patient to self inject entails a high risk of infection in the epidural or intrathecal space, which can lead to permanent neurologic damage or even death. The risk is well recognized when allowing cancer patients to self inject, but is not acceptable with non-cancer patients. Twice the patient had to be seen in various emergency rooms for adverse reactions to self-injected narcotics. (See paragraphs 28 and 40 hereinabove). Once she had to be hospitalized for an infection at the site of the catheter itself. (See paragraph 44). This demonstrates that respondent used poor clinical judgment in starting, continuing and in failing to adequately manage epidural narcotics as well as steroids.

H. Respondent incompetently and/or negligently and/or grossly negligently used deposteroids in the epidural space. There is no indication that use of steroids given epidurally has any affect [sic] on RSD. In addition, if respondent understood the mechanism of action of deposteroids, in that they continue to exert their effect for 2-3 weeks, he would have known that there was no indication to inject the steroids daily.

I. Respondent incompetently and/or negligently and/or grossly negligently performed procedures, such as the surgical placement of temporary and permanent indwelling DuPen catheters, numerous times, in a technically inadequate fashion, in an environment that was not aseptic and without use of a surgery center where these procedures are typically done. In addition, respondent does not have the required "licensed surgery center" accreditation to perform said procedures in his office. If

respondent actually thought that epidural narcotics was the only way to manage patient A.C.'s care, he could have implanted a narcotic infusion pump and spinal catheter which would have enabled him to exercise responsible charge of the amount of narcotic to be administered and at the same time have provided an aseptic, totally enclosed (under the skin) system.

J. In spite of the fact that there was no sustained response to the epidural or sympathetic nerve blocks, respondent repeated them over a period of months. Respondent should have known that if the injections were continued, each injection should have provided a more long lasting pain relief period. If this does not occur, then the patient is not responding to the nerve blocks and they should be abandoned, or a neurolytic block performed.

K. Respondent prescribed numerous narcotics without evaluating the patient's response other than her subjective report of pain relief. She continued to rapidly escalate the dose and not keep detailed accounts of the medication that she was using. Without any objective improvement in her pain, and with the massive escalation in narcotic usage from Demerol to Morphine and Methadone, the continuing use of these narcotics was contraindicated. In fact, the patient repeatedly demonstrated her control of the treatment regimen, as noted hereinabove, even to the extent that she was provided Narcan, in a syringe, to take home with her to self administer, without any notation as to the amount, and which was given to her "attendant" son. (See paragraph 32 hereinabove). She also insisted that despite a low grade fever

and tenderness at the epidural catheter site that the catheter be left in place. (See paragraph 34 hereinabove).

L. Respondent caused patient A.C. to undergo, without medical indication or justification, numerous spinal anesthetics with local anesthetic and narcotics. These procedures were without any diagnostic or therapeutic value and constitute both clearly excessive use of diagnostic and/or treatment procedures and an extreme departure from the standard of practice among the community of California licensed physicians practicing pain management.

50. Respondent's conduct as alleged in paragraphs 22 through 49, subparagraphs A through L, detailing the treatment and professional care provided to patient A.C., constitutes gross negligence and/or repeated negligent acts and/or incompetence and is grounds for disciplinary action pursuant to Business and Professions Code sections 2234(b), (c) and/or (d).

51. Further, respondent's conduct as alleged in paragraphs 22 through 49, subparagraphs A through L, detailing the treatment and professional care provided to patient A.C., constitutes repeated acts of clearly excessive use of diagnostic or treatment procedures (spinal anesthetics via epidural catheters) as determined by the standard of the community of licenses in violation of section 725 of the Code subjecting respondent's certificate as a physician and surgeon to discipline for unprofessional conduct pursuant to section 2234 of the Code.

52. Pursuant to Business and Professions Code section 125.3, in any order issued in resolution of a disciplinary proceeding, the Board may request the administrative

law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

WHEREFORE, complainant requests that the Board hold a hearing on the matters hereinabove, as well as the matters alleged in the original accusation presently on file against respondent, and after that hearing issue an order;

1.) Suspending or revoking physician's surgeon's certificate No G 39260, heretofore issued to Respondent Franklin Jerome Day, M.D.;

2.) Granting the Medical Board of California its reasonable costs of investigation and prosecution of this case; and

3.) Taking such other and further action as is deemed just and proper.

Dated: Oct. 13, 1995.

/s/ Doug Laue
DOUG LAUE
Acting Executive Director
Medical Board of California
State of California
Complainant

COPY

IN THE SUPREME COURT
OF CALIFORNIA

NELSON F. LEONE, Plaintiff and Appellant, v. MEDICAL BOARD OF CALIFORNIA, Defendant and Respondent.	S065485 Ct.App. 2/4 B103344 Los Angeles County Super. Ct. No. BS035371
SHASHI D. GANTI, Plaintiff and Appellant, v. MEDICAL BOARD OF CALIFORNIA, Defendant and Respondent.	Ct. App. 2/4 B101297 Los Angeles County Super. Ct. No. BS036241 (Filed Apr. 3, 2000)

The Medical Board of California (MBC), a state administrative agency, has authority to discipline a physician for unprofessional conduct by restricting, suspending, or revoking the physician's license to practice medicine. (Bus. & Prof. Code, § 2227.) A physician whom the MBC has disciplined in this way may obtain judicial review of the MBC's order by commencing an administrative mandate proceeding. (Code Civ. Proc., § 1094.5.) The superior court has original jurisdiction of these administrative mandate proceedings. (Cal. Const., art. VI, § 10.) For this limited category of actions, the Legislature has provided that the Court of Appeal shall review the superior court's decision, not by direct appeal, but "pursuant

to a petition for an extraordinary writ." (Bus. & Prof. Code, § 2337; hereafter section 2337.)

We granted review in this case to decide whether section 2337 – making a writ petition the method for obtaining appellate review of superior court decisions in these physician licensing matters – violates the clause of the California Constitution stating that, except when a judgment of death has been pronounced, "courts of appeal have appellate jurisdiction when superior courts have original jurisdiction. . . . " (Cal. Const., art. VI, § 11.) Consistent with our resolution of a similar question in *Powers v. City of Richmond* (1995) 10 Cal.4th 85 (hereafter *Powers*), we hold that section 2337 does not violate this appellate jurisdiction clause of the California Constitution.

I

The MBC's Division of Medical Quality separately charged Dr. Nelson F. Leone, a psychiatrist, and Dr. Shashi D. Ganti, an ophthalmologist, with professional misconduct. For each physician, a hearing before an administrative law judge resulted in a recommendation of license revocation. The MBC adopted each of these recommendations and ordered the physicians' licenses revoked. Each physician sought and obtained judicial review of the MBC's adverse decision by petitioning the superior court for a writ of administrative mandate. In each of these judicial proceedings, the superior court upheld the license revocation.

Notwithstanding section 2337, which makes an extraordinary writ petition the exclusive method for

obtaining appellate review of a superior court decision in a physician license revocation matter, Drs. Leone and Ganti each filed a notice of appeal. Relying on section 2337, the MBC moved in the Court of Appeal to dismiss both appeals. For the purpose of ruling on these motions, the Court of Appeal consolidated the two appeals. It then heard oral argument and issued a single opinion in which it denied the MBC's motions to dismiss. The Court of Appeal construed the appellate jurisdiction clause of the California Constitution as granting litigants a constitutional right of appeal, and it held section 2337 unconstitutional because, as the Court of Appeal put it, "the Legislature does not have the power to destroy the right of an appeal that is constitutionally granted."

This court granted the MBC's petition for review, which framed the issues this way:

"1. Does the Legislature have the authority to specify the mode of appellate review of physician discipline without infringing on the 'appellate jurisdiction' of the appellate court under article VI, section 11 of the California Constitution?

"2. Is Business and Professions Code section 2337 constitutional under California's Constitution, article VI, section 11, to the extent that it specifies the mode of appellate review of a superior court's decision regarding physician discipline and permits appellate review solely by extraordinary writ?"

II

Plaintiff doctors contend that the California Constitution's appellate jurisdiction clause grants them a right of direct appeal from final judgments in administrative mandate proceedings in which superior courts exercise original jurisdiction. In their view, this constitutional right of appeal necessarily includes the rights to oral argument, a decision on the merits, and a written opinion explaining the basis of the appellate court's decision. Plaintiffs contend that section 2337 violates this constitutional right of appeal because it precludes them from appealing the superior courts' judgments in their administrative mandate actions and because it relegates them to seeking review by an extraordinary writ petition that a Court of Appeal may deny summarily, without hearing oral argument or issuing a written opinion.

A majority of this court rejected the core of plaintiff's argument in *Powers, supra,* 10 Cal.4th 85, concluding instead that the appellate jurisdiction vested in the Courts of Appeal by article VI, section 11, of the California Constitution encompasses review by extraordinary writ as well as review by direct appeal. (*Powers, supra,* at pp. 92-93 (plur. opn. of Kennard, J.); *id.* at p. 122 (conc. opn. of George, J.).) The Court of Appeal in this case failed to recognize that the plurality and concurring opinions in *Powers* agreed on this crucial point. Although *Powers* provides controlling authority that makes further analysis unnecessary, we summarize the reasoning of the *Powers* plurality that supports this conclusion.

When construing a constitution, courts view as the paramount consideration the intent of those who enacted

the provision at issue. (*Davis v. City of Berkeley* (1990) 51 Cal.3d 227, 234.) To determine that intent, courts look first to the language of the constitutional text, giving the words their ordinary meaning. (*Ibid.*; see also *Bowens v. Superior Court* (1991) 1 Cal.4th 36, 48; *Lungren v. Deukmejian* (1988) 45 Cal.3d 727, 735.)

The constitutional text at issue here is this:

"The Supreme Court has appellate jurisdiction when judgment of death has been pronounced. With that exception courts of appeal have appellate jurisdiction when superior courts have original jurisdiction. . . . " (Cal. Const., art. VI, § 11.)

Nothing in this language conveys an intention to grant litigants a right of direct appeal from judgments in proceedings within the superior courts' original jurisdiction. "Giving the words their ordinary meaning, the provision serves to establish and allocate judicial authority, not to define or guarantee the rights of litigants. Indeed, the provision nowhere mentions direct appeals or a 'right of appeal.' " (*Powers, supra*, 10 Cal.4th 85, 91 (plur. opn. of Kennard, J.).)

In particular, the reference to "appellate jurisdiction" does not imply a right of litigants to bring direct appeals. A legal dictionary defines "appellate" as "[p]ertaining to or having cognizance of *appeals and other proceedings for the judicial review of adjudications.*" (Black's Law Dict. (6th ed. 1990) p. 97, col. 2, italics added.) The same dictionary defines "appellate jurisdiction" as "[t]he power vested in an appellate court to review and revise the judicial action of an inferior court" and as "the power of review and

determination *on appeal, writ of error, certiorari, or other similar process.*" (*Id.* at p. 98, col. 1, italics added.)

The United States Supreme Court has declared that the "essential criterion of appellate jurisdiction" is "that it revises and corrects the proceedings in a cause already instituted, and does not create that cause." (*Marbury v. Madison* (1803) 5 U.S. (1 Cranch) 137, 175 [2 L.Ed. 60, 73].) Applying this definition, the high court has concluded that a court exercises appellate jurisdiction when it reviews a lower court's decision in ruling on a petition for a writ of habeas corpus. (*Ex Parte Watkins* (1833) 32 U.S. (7 Pet.) 568, 572 [8 L.Ed. 786, 788].) Courts in other states have defined "appellate jurisdiction" similarly. (See *Powers, supra,* 10 Cal.4th 85, 92-93 (plur. opn. of Kennard, J.), and cases cited therein.)

Thus, the ordinary and widely accepted meaning of the term "appellate jurisdiction" is simply the power of a reviewing court to correct error in a trial court proceeding. By common understanding, a reviewing court may exercise this power in the procedural context of a direct appeal or a writ petition.

A review of the process that resulted in adoption of the California Constitution's appellate jurisdiction clause reinforces this construction. The voters enacted the appellate jurisdiction clause in substantially its present form at the November 8, 1966 General Election, when the previous article VI was repealed and its provisions revised and redistributed. This comprehensive revision of the provisions concerning the judicial branch of state government was largely drafted by the California Constitutional

Revision Commission, and a court may consult the commission's official reports to determine the intent and objective of ambiguous provisions. (*Mosk v. Superior Court* (1979) 25 Cal.3d 474, 495.) The records of the commission's official proceedings reveal that its main objective in revising article VI was "to delete provisions which were redundant, obsolete, or unnecessary for inclusion in the Constitution, such as procedural matters which could be prescribed or provided for by statute or court rule." (*Mosk v. Superior Court, supra,* at p. 496.) By removing unnecessary provisions from article VI, and allowing many of those matters to be regulated by statute, the commission's revisions of article VI effectively broadened the scope of the Legislature's control over judicial procedures.

In its report recommending adoption of section 11 of article VI, the commission gave this explanation: "This section collects those parts of existing Sections 4, 4b, 4e, and 5 that deal with appellate jurisdiction. Some of the existing sections contain detailed references to instances of appellate jurisdiction. The Commission deleted those references as unnecessary in the Constitution except in death penalty cases where, because of the extreme nature of the penalty, jurisdiction was given to the Supreme Court. [¶] The phrase 'on questions of law alone,' as a description of appellate jurisdiction in criminal causes when judgment of death has been rendered was deleted as unnecessary since this is the ordinary scope of review in appellate courts." (Cal. Const. Revision Com., Proposed Revision (1966) p. 91.)

In the records of the commission's proceedings and reports bearing on the appellate jurisdiction provision,

we find not a single reference to a litigant's right of appeal, nor anything suggesting that the commission intended that the appellate jurisdiction clause would confer on litigants a right to a direct appeal. Nor does the ballot pamphlet for the November 1966 election mention a right of appeal under the state Constitution.

In its decision, the Court of Appeal here relied on statements in certain early court decisions referring to a right of appeal under the state Constitution. (See *Byers v. Smith* (1935) 4 Cal.2d 209, 213-214; *In re Sutter-Butte By-Pass Assessment* (1923) 190 Cal. 532, 536; *People v. Perry* (1889) 79 Cal. 105, 107.) For several reasons, this reliance was misplaced. None of these decisions construed the current appellate jurisdiction clause, enacted in November 1966, and none addressed the constitutional validity of a legislative scheme making a writ petition the exclusive mode of appellate review of a superior court proceeding. The courts authoring these decisions appear to have used the term "appeal" to encompass a right to appellate review generally, without distinguishing between review by writ petition and review by direct appeal. Finally, many contemporaneous and later decisions of this court and the Courts of Appeal stated that the right of appeal is entirely statutory and that there is no constitutional right of appeal. (See *Powers, supra*, 10 Cal.4th 85, 105-108 (plur. opn. of Kennard, J.), and cases cited therein.)

Because a reviewing court may exercise appellate jurisdiction – that is, the power to review and correct error in trial court orders and judgments – either by a direct appeal or by an extraordinary writ proceeding, the

clause of the state Constitution conferring appellate jurisdiction on the Courts of Appeal "does not necessarily or strongly imply a right of litigants to bring direct appeals" from judgments in civil proceedings within the superior court's original jurisdiction. (*Powers, supra*, 10 Cal.4th 85, 93, 105-108 (plur. opn. of Kennard, J.).) Rather, that constitutional provision is properly construed as generally permitting the Legislature to enact laws, such as section 2337, specifying that an extraordinary writ petition shall be the method for obtaining appellate review of a superior court judgment in an administrative mandate proceeding.

The Legislature's authority to specify the mode of appellate review of superior court judgments is subject to an important qualification. Because the appellate jurisdiction clause is a grant of *judicial* authority, the Legislature may not restrict appellate review in a manner that would " 'substantially impair the constitutional powers of the courts, or practically defeat their exercise.' " (*In re Jessup* (1889) 81 Cal. 408, 470, italics omitted, quoting *Ex Parte Harker* (1875) 49 Cal. 465, 467.) "If it could be demonstrated in a given case, or class of cases, that, for whatever reason, the Courts of Appeal or this court could not effectively exercise the constitutionally granted power of appellate review by an extraordinary writ proceeding, then such a proceeding could not constitutionally be made the exclusive mode of appellate review." (*Powers, supra*, 10 Cal.4th 85, 110 (plur. opn. of Kennard, J.).)

Relying on this qualification, plaintiff doctors argue that section 2337 substantially impairs the exercise of

appellate jurisdiction because the percentage of extraordinary writ petitions that the Courts of Appeal summarily deny is greater than the percentage of direct appeals in which the Courts of Appeal affirm the superior court's judgment. We find the argument entirely unpersuasive.

Plaintiffs cite no relevant statistics demonstrating that, when a writ petition is the exclusive method of appellate review of a final judgment, the Courts of Appeal summarily deny writ petitions with greater frequency than they affirm judgments on direct appeal in comparable proceedings. This lack of relevant supporting data is by itself sufficient reason to reject this argument. In addition, the argument lacks any coherent logic. We perceive no reason to infer from the frequency of summary denials that extraordinary writ review is not a sufficient or effective appellate remedy in physician discipline proceedings. Section 2337 does not limit the kinds of superior court error that the Court of Appeal may correct, the record that the Court of Appeal may consider, or the time the Court of Appeal may devote to appellate review. Nor does it prevent the Court of Appeal, when a petition appears to have merit, from hearing oral argument or issuing a written opinion. Thus, nothing in section 2337 substantially impairs a Court of Appeal's ability to effectively exercise its power to review and correct error in superior court administrative mandate decisions in physician discipline matters.

Finally, Dr. Leone argues that even if section 2337 does not on its face violate the appellate jurisdiction clause of the California Constitution, Courts of Appeal

may not deny extraordinary writ petitions in these physician discipline cases summarily, without an order to show cause or alternative writ, oral argument, and a written opinion. Dr. Leone asserts that a summary writ denial is not an exercise of jurisdiction and thus cannot not [sic] satisfy an appellate court's obligation to exercise the appellate jurisdiction with which it is constitutionally vested. This argument also fails.

A reviewing court's obligation to exercise the appellate jurisdiction with which it is vested, once that jurisdiction has been properly invoked, is established and not open to question. (See *Colorado River Water Conservation Dist. v. United States* (1976) 424 U.S. 800, 817; *People v. Jordan* (1884) 65 Cal. 644, 646.) We do not agree with Dr. Leone, however, that a Court of Appeal fails to exercise its appellate jurisdiction when it summarily denies an extraordinary writ petition that lacks substantive merit or is procedurally defective.

As authority for the proposition that a Court of Appeal fails to exercise jurisdiction when it summarily denies an extraordinary writ petition, Dr. Leone relies on this court's decision in *Kowis v. Howard* (1992) 3 Cal.4th 888. In that case, we held that a summary denial of a writ petition on a pretrial issue does not establish the law of the case. In the course of explaining that holding, we made this statement, on which Dr. Leone relies: "When the court denies a writ petition without issuing an alternative writ, *it does not take jurisdiction over the case;* it does not give the legal issue full plenary review." (*Id.*, at p. 897.) The italicized statement was addressed to writ petitions challenging pretrial superior court rulings that could also be reviewed on appeal from the judgment

ultimately entered in the action; it was not addressed to situations in which a writ petition was the only authorized mode of appellate review. In the latter situation, an appellate court must judge the petition on its procedural and substantive merits, and a summary denial of the petition is necessarily on the merits. (See *Powers, supra,* 10 Cal.4th 85, 113-114 (plur. opn. of Kennard, J.); *Dowell v. Superior Court* (1956) 47 Cal.2d 483, 486-487; *May v. Board of Directors* (1949) 34 Cal.2d 125, 133-134.) An appellate court that summarily denies a writ petition for lack of substantive merit or for procedural defect thereby fulfills its duty to exercise the appellate jurisdiction vested in it by the state Constitution's appellate jurisdiction clause.

Plaintiff doctors argue that section 2337 not only violates the appellate jurisdiction clause of the state Constitution, but also denies them due process and equal protection. Because these due process and equal protection claims are outside the issues on which we granted review, and because the Court of Appeal has not yet addressed them, we decline to consider them at this time. The Court of Appeal will address these issues on remand.

III

In section 2337, the Legislature has determined that for superior court decisions in certain physician licensing matters, the mode of appellate review shall be an extraordinary writ proceeding rather than direct appeal. To determine whether, as plaintiff doctors contend, the appellate jurisdiction clause of the state Constitution forbids this legislative choice, we have examined the text and history of this constitutional provision. We conclude

that the appellate jurisdiction clause does not require the Legislature to provide for direct appeals in all cases within the original jurisdiction of the superior courts; that it permits some variation in and experimentation with the procedures for appellate review of civil actions brought in the superior courts, provided always that the constitutional powers of the courts are not thereby impaired; and that in particular it does not guarantee a physician a right to a direct appeal from a superior court administrative mandate judgment upholding the MBC's revocation of the physician's license to practice medicine.

The judgment of the Court of Appeal denying the MBC's motions to dismiss is reversed, and the matter is remanded to that court for further proceedings consistent with this opinion.

KENNARD, J.

WE CONCUR:

BAXTER, J.
WERDEGAR, J.
CHIN, J.

CONCURRING OPINION BY GEORGE, C.J.

I concur in the holding of the majority that Business and Professions Code section 2337 (section 2337) does not violate article VI, section 11, of the California Constitution. Appellate review of superior court judgments entered upon review of administrative orders revoking, suspending, or restricting a physician's license to practice

medicine may be limited to review by petition for extraordinary writ without violating the appellate jurisdiction clause of the California Constitution.

I would analyze the issue, however, in the manner explained in my concurring opinion in *Powers v. City of Richmond* (1995) 10 Cal.4th 85 (*Powers*). There I cautioned against any holding that would permit the Legislature to undertake wholesale replacement of direct appeal with review by extraordinary writ (*Id.* at pp. 116, 124 (conc. opn. of George, J.)), thereby "restructur[ing], in a fundamental manner, the operation of the state's appellate process." (*Id.* at p. 117.) Focusing upon the authority of the appellate courts, the concurring opinion suggested that legislation might violate article VI, section 11, of the California Constitution if it transformed the Court of Appeal "from an appellate tribunal whose duties generally involve the resolution of cases in which litigants have a direct appeal 'as a matter of right' – and in which most decisions must be rendered 'in writing with reasons stated' [citation] – into an appellate court whose jurisdiction consists *entirely* of writ review and as to which the court has no obligation to resolve *any* of the cases before it by a written decision setting forth the reasons for its ruling." (*Powers, supra,* 10 Cal.4th at p. 116 (conc. opn. of George, J.), italics in original.)

In addition, the concurring opinion suggested that in some instances, from the perspective of the *parties* to an action, "the nature or subject matter" under review or "the nature of the particular rights or interests at stake" might signify that "adequate appellate review" could be provided "only by direct appeal, and not by extraordinary writ." (*Powers, supra,* 10 Cal.4th at p. 121 (conc. opn.

of George, J.), italics omitted.) The concurring opinion also suggested that the wholesale elimination of direct review from entire classes of cases could implicate not only the authority of the appellate courts, but also the rights of the parties. (*Id.* at p. 124.)

I agree with the majority in the present case that there is no basis for concluding that the judicial power of the appellate courts is impaired when review of judgments in administrative mandate actions in cases of physician discipline is limited to extraordinary writ. This restriction affects only a very narrow class of cases, and the essential function of the reviewing court is not threatened. There is no claim that the instances in which the Legislature has provided for writ review of lower court orders and judgments are so numerous that cumulatively the appellate process has been transformed to an extent that the exercise of the power of the appellate courts has been impaired. Further, the judicial power of the appellate courts is exercised *effectively* when review is sought by extraordinary writ (see *Powers, supra,* 10 Cal.4th at pp. 113-114 (lead opn. of Kennard, J.).) Indeed, the provision limiting plaintiffs to writ review does not limit the record that the appellate court may consider. The administrative proceeding is recorded (Gov. Code, § 11512, subd. (d)), and this record generally is submitted to the superior court with a petition for administrative mandate (Code Civ. Proc., § 1094.5, subd. (a); *Alford v. Pierno* (1972) 27 Cal.App.3d 682, 691) and normally also would be presented to the Court of Appeal. (See *Sherwood v. Superior Court* (1979) 24 Cal.3d 183, 186-187.) This provision does not limit the time the Court of Appeal may choose to devote to the evaluation of the writ petition. Further, in

any case in which the Court of Appeal's assessment of the petition leads it to conclude that the petition may have merit, the appellate court may issue an alternative writ and obtain additional briefing and oral argument. Thus, from the point of view of the Court of Appeal, there is no indication that writ review under section 2237 would prevent that court from exercising its appellate power effectively.

With respect to the additional concern noted in the concurring opinion in *Powers* – the rights of the litigants – section 2337 is within the constitutional latitude recognized by that opinion in permitting legislative innovation, since the statutory provisions are "compatible with the particular issue or ruling subject to review and . . . serve to promote a fair and efficient judicial system." (*Powers, supra,* 10 Cal.4th at p. 123 (conc. opn. of George, J.).) The restriction on appellate review serves a significant public interest in the speedy removal of incompetent physicians from the practice of medicine (see *Kees v. Medical Board* (1992) 7 Cal.App.4th 1801, 1813 [government has a pressing need to protect the public from the risk of harm presented by physicians who cannot practice medicine safely].) Moreover, the statutory procedure for reviewing an administrative decision revoking, suspending, or modifying a physician's license to practice medicine includes what is essentially the equivalent of a direct appeal – the physician is afforded the right to a full and complete hearing at the administrative level, and then has the right to obtain review of the administrative decision through administrative mandate in the superior court.

Plaintiffs, relying upon language in the concurring opinion in *Powers, supra,* 10 Cal.4th at page 121, contend that with respect to both "the nature of the subject matter" and "the nature of the particular rights at stake," section 2337 is distinguishable from the Public Records Act provision at issue in *Powers,* and that in light of these distinctions it is appropriate to conclude that adequate appellate review may be provided only by direct appeal and not by extraordinary writ. It is true, as plaintiffs maintain, that the right to practice their profession is a vested right (see *Unterthiner v. Desert Hospital. Dist.* (1983) 33 Cal.3d 285, 297), the deprivation of which has great significance to the affected individual. It is also true, as plaintiffs contend, that the proceedings resulting in a disciplinary sanction in many instances may be significantly more protracted, and more factually and legally complex, than those presented in a typical Public Records Act controversy. And it is also true that, unlike the Public Records Act provisions at issue in *Powers,* section 2337 – though similarly intended to speed the resolution of litigation through the substitution of writ review for direct appeal – was not enacted to promote the interests of the affected parties, in this instance physicians.

Nonetheless, certain factors weigh heavily against plaintiffs' claim that extraordinary writ review in the Court of Appeal does not afford adequate appellate review in the cases to which section 2337 applies. First, although plaintiffs undoubtedly possess a very significant interest in continuing to practice their profession, this interest properly is subject to legislative control. As we have observed, " '[t]he general right to engage in a trade, profession or business is subject to the power

inherent in the state to make necessary rules and regulations respecting the use and enjoyment of property necessary for the preservation of the public health, morals, comfort, order and safety. . . . [Citation.] No person can acquire a vested right to continue, when once licensed, in a business, trade or occupation which is subject to legislative control under the police powers.' " (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 790.)

Moreover, in the Public Records Act action at issue in *Powers*, the superior court proceeding that was subject to review by extraordinary writ was the initial and *only* proceeding to address the litigants' Public Records Act claim. By contrast, the proceedings to which section 2337 applies are administrative mandate proceedings, in which, as noted, the superior court itself essentially provides a direct appeal from extensive quasi-judicial administrative proceedings. In a manner consistent with their significant interest in continuing to practice their profession, physicians are afforded a panoply of procedural safeguards at the administrative level, and the hearing before the administrative law judge is in many respects comparable to an initial trial before a superior court in an ordinary civil action. When a physician challenges a decision of the administrative law judge that has been adopted by the medical board, the parties may file the entire administrative record with the superior court (Code Civ. Proc., § 1094.5, subd. (a)), and that court determines whether the administrative body "has proceeded without, or in excess of jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of discretion." (Code Civ. Proc. § 1094.5, subd. (b).) If it is claimed that the administrative findings are not

supported by the evidence, the court exercises its independent judgment. (Code Civ. Proc. § 1094.5, subd. (c); *Yellen v. Board of Medical Quality Assurance, supra,* 174 Cal.App.3d at pp. 1057-1058.) In addition, the parties are entitled to a written decision upon request. (Code Civ. Proc., § 632.)

It is evident, accordingly, that the superior court entertains what is closely comparable to a direct appeal from the administrative decision. In this setting, the further appellate review that the physician may seek in the Court of Appeal provides a *second* check on any possible error. Accordingly, because the superior court already will have reviewed the administrative record in the manner described, the distinctions drawn by plaintiffs between Public Records Act proceedings and the proceedings to which section 2337 applies do not demonstrate that limiting appellate review in the present context to extraordinary writ review imposes any greater intrusion on a party's interests in adequate appellate review than the procedures applicable in the Public Records Act context.

In light of the extensive protections afforded physicians at the administrative level and, most particularly, at the superior court level, and considering the important public interest in imposing timely discipline upon physicians, I believe that exclusive review of a superior court judgment in an administrative mandate proceeding by extraordinary writ in these circumstances is "compatible with the particular issue or ruling subject to review and . . . , at the same time, serve[s] to promote a fair and efficient judicial system." (*Powers, supra,* 10 Cal.4th at p. 123 (conc. opn. of George, J.).)

Having expressed these views, in future cases I shall be bound by the broader rule established by the majority in the present case.

GEORGE, C.J.

DISSENTING OPINION BY MOSK, J.

I joined the dissent in *Powers v. City of Richmond* (1995) 10 Cal.4th 85, 124 (*Powers*), which concluded, after extensive historical review, that article VI, section 11 of the California Constitution was intended to give litigants who had their cause adjudicated in superior court a right of direct appeal that could not be supplanted by discretionary writ review. The majority today formulate a position to which only three justices on the *Powers* court assented – that the Legislature has the virtually unlimited authority to substitute writ proceedings for appeal. I cannot agree.

The differences between review by writ and by appeal are not merely formal or theoretical. Despite the majority's clarification that when a writ is the only means of appellate review, denial of the writ must necessarily be on the merits (maj. opn., *ante*, at p. 10), it can hardly be doubted that writ review affords fewer procedural protections. This is so because writ review lacks those basic components of ordinary appellate review – oral argument and a written opinion – that ensure the merits of an appeal will be fairly considered. "Oral argument provides the only opportunity for a dialogue between the litigant

and the bench. As a result, 'it promotes understanding in ways that cannot be matched by written communication.' [Citation.] For example, in complex cases, oral argument 'provides a fluid and rapidly moving method of getting at essential issues.' In the words of one judge, ' "Mistakes, errors, fallacies and flaws elude us in spite of ourselves unless the case is pounded and hammered at the Bar." ' [Citations.] [¶] No proof of the value of oral argument is more compelling, however, 'than the fact that many judges find that the opportunity for a personal exchange with counsel makes a difference in result.' This aspect of oral argument – the chance to make a difference in result – is extremely valuable to litigants." (*Moles v. Regents of University of California* (1982) 32 Cal.3d 867, 872.) We know too, from personal experience, that when a reviewing court must account for its conclusions in a written opinion, even if that opinion is not published in the official records, there is a greater likelihood that it will carefully analyze the merits. For reasons fully articulated by the dissent in *Powers*, I continue to be persuaded that a right of direct appeal – including oral argument and a written opinion – is what the drafters of article VI, section 11 and its predecessor sections had in mind by "appellate jurisdiction."

Unlike the lead opinion in *Powers*, and the majority today, the concurring opinion in *Powers* proposed a narrow holding. It focused primarily on the statute before it, the Public Records Act (Gov. Code, § 6250 et seq.). It concluded that requiring appellate review by extraordinary writ in such a case did not violate article VI, section 11, in part because the Legislature "determined that appellate review by extraordinary writ, rather than by

direct appeal, would better protect the rights afforded by the Public Records Act." (*Powers, supra,* 10 Cal.4th 85, 123 (conc. opn. of George, J.).) Implicit in this position is the assumption that the Legislature may substitute writ review for that of direct appeal if such substitution advances an important legislative objective. But assuming arguendo that this position is correct, and that rights under the Public Records Act were indeed best protected by resort to an expeditious writ, in the present case I find that no such legislative objective is advanced. It is not claimed that review by extraordinary writ under Business and Professions Code section 2337 will better protect the right of physicians to practice their profession. On the contrary, the substitution of writ review for direct appeal is inconsistent with the heightened constitutional protections afforded someone who is in danger of losing a vested right to practice his or her profession. (See *Unterthiner v. Desert Hospital Dist.* (1983) 33 Cal.3d 285, 297.)

The concurring opinion in the present case would justify the restriction on appellate review in part by the "significant public interest in the speedy removal of incompetent physicians from the practice of medicine." (Conc. opn., *ante,* at p. 3.) But the requirement of writ review does not substantially advance this interest. Once the Medical Board of California has suspended or revoked a physician's license, a physician can only obtain a stay of the order if it is granted by the superior court to which he or she has applied for a writ of mandate. (Code Civ. Proc., § 1094.5, subd. (h)(1).) A stay may be granted only if "the court is satisfied that the public interest will not suffer and that the [licensing] agency is unlikely to

prevail ultimately on the merits" (*ibid.*), which means that the court must convince itself that the physician is likely to prevail on the merits (*Board of Medical Quality Assurance v. Superior Court* (1980) 114 Cal.App.3d 272, 276). Thus, the medical board already has the power to timely remove from practice incompetent or unscrupulous physicians, and further restriction on the ability to grant a stay may be legislated without the need to eliminate a right of appeal.

In short, the majority and concurring opinions in this case do not merely follow *Powers*, but significantly broaden it by expanding the class of cases in which the Legislature may deny the constitutional right of appeal. I cannot join them in that enterprise.

MOSK, J.

DISSENTING OPINION BY BROWN, J.

"The bald truth is this, isn't it, that the power to regulate jurisdiction is actually a power to regulate rights – rights to judicial process . . . and substantive rights generally?" (Hart, *The Power of Congress to Limit the Jurisdiction of Federal Courts: An Exercise in Dialectic* (1953) 66 Harv. L.Rev. 1362, 1371.) Henry Hart was, of course, questioning the power of Congress to restrict the jurisdiction of the federal courts in his justly famous Dialogue of almost half a century ago. Yet the principle enunciated by Professor Hart applies with even greater force to this case.

Dissenting in the *Powers* case (*Powers v. City of Richmond* (1995) 10 Cal.4th 85, 125 (*Powers*)), Chief Justice Lucas gave an exhaustive account of the historical materials bearing on the question of the framers' intent in adopting our constitutional "right of appeal" provision. As that opinion compellingly demonstrates, what the framers of now article VI, section 11 of the California Constitution (hereafter article VI, section 11) intended to secure for the citizens of California was a constitutional right of direct appeal to a reviewing court, a right that included oral argument and an opinion in writing on the merits of the case. (*Id.* at p. 141 [Quoting Delegate Wilson at the 1879 convention that " '[t]he importance of requiring the Court to give written opinions cannot be overrated. . . . It tends to purity and honesty in the administration of justice.' ([2 Willis & Stockton, Debates and Proceedings, Cal. Constitutional Convention (1878-1879)] at p. 951, col. 1."].) Rather than confer on the Legislature the power to make exceptions to appellate jurisdiction – not just the federal model but the dominant state model of the day – the framers of the 1849 and 1879 California provisions instead expressly described the jurisdiction conferred on our appellate courts, following the example set by Louisiana. (*Id.* at pp. 134-137.)

Unfortunately, a plurality of the court in *Powers* rejected that view of the meaning of article VI, section 11; a rejection today's majority affirms. Not only does that holding mark an epochal change in the understanding of the appellate rights of California litigants, in effect, it threatens to overturn the conception of a constitutionally rooted, truly independent judiciary. From now on, the sole limitation on the Legislature's otherwise plenary

power to manipulate the jurisdiction of California's appellate courts is the notion that such statutory enactments may not " ' "substantially impair the constitutional powers of the courts, or practically defeat their exercise." ' " (Maj. opn., *ante*, at p. 8, quoting *In re Jessup* (1889) 81 Cal. 408, 470.)

The concurring opinion advances a similar but more elaborated standard to protect the appellate courts from legislative overreaching: legislation cannot constitutionally "transform[ ] the Court of Appeal 'from an appellate tribunal whose duties generally involve the resolution of cases in which litigants have a direct appeal "as a matter of right" . . . into an appellate court whose jurisdiction consists entirely of writ review and as to which the court has no obligation to resolve any of the cases before it by a written decision setting forth the reasons for its ruling.' " (Conc. opn. of George, C.J., *ante*, at p. 1, quoting *Powers, supra*, 10 Cal.4th at p. 116, italics omitted.) Would it were so.

The tripartite structure of government and the separation of powers doctrine that underlies it are not ends in themselves; the issue is not one of governmental "turf." The structural divisions of the Constitution are intended to promote the chief aim of our government – individual liberty. (See Miller, *Liberty and Constitutional Architecture: The Rights-Structure Paradigm* (1993) 16 Harv. J.L. & Pub. Pol'y 87; Brown, *Separated Powers and Ordered Liberty* (1991) 139 Pa. L.Rev. 1513.) It is that concern – the potential for the impairment of individual liberty through the impairment of the structural powers of the judiciary – that is at the root of my disagreement with the majority in

this case. The fear of an insensible, aggrandizing "tyranny" that underlies the structural division of government is timeless; as real today as it was in 1879, in 1849, and in 1776. And, "[c]entral to [the concept of separation of powers] are three . . . insights: (1) the very fact of the concentration of political power in the hands of one governmental organ is unacceptable, even absent a showing of misuse of that power; (2) it will, as a practical matter, be all but impossible to determine when the level of the concentration of political power has reached the danger point; and (3) the point at which such an unacceptable concentration is actually reached is too late for the situation to be remedied." (Redish & Cisar, *"If Angels Were to Govern": The Need for Pragmatic Formalism in Separation of Powers Theory* (1991) 41 Duke L.J. 449, 476, fn. omitted.)

I agree with Edmund Burke that the first virtue of politics is prudence. (See Burke, The Philosophy of Edmund Burke, Prudence as a Political Virtue (1970) p. 38; *id.* at p. 41 ["Prudence is not only the first in rank of the virtues political and moral, but she is the director, the regulator, the standard of them all."].) The appetite for power by the departments of government is, as Madison wrote, "of an encroaching nature." (Madison, The Federalist No. 48 (Rossiter ed. 1961) p. 308.) Its accretion leads to even greater accretion. Short of a coup d'etat, legislative aggrandizement need not – indeed, likely will not – assume a dramatic form. More probably, as in this case, it appears in the form of legislators "eagerly bent on some favorite object, and breaking through the restraints of the Constitution in pursuit of it. . . . " (Madison, The Federalist No. 50, *supra*, at p. 318.) And it is for that very reason, as Thomas Jefferson wrote, that "[t]he time to guard

against . . . tyranny, is before [it] shall have gotten hold on us." (Jefferson, Notes on the State of Virginia (Peden ed. 1982) p. 121.) It is not the last invasive stroke on the judiciary's constitutional prerogatives that should mobilize resistance, but the first. This truism of politics is the reason the limitations on legislative power endorsed in the majority and concurring opinions will protect neither the courts nor the people of California. Or, put another way, would protect them only if, in Madison's striking phrase, "angels were to govern." (Madison, The Federalist No. 51, *supra,* at p. 322.)

In my view, where the Legislature has asserted control over the right of appeal – a subject central to the judicial function – a case-by-case inquiry into the likelihood of adverse effects in the wake of a separation of powers breach is ill-conceived. It is ill-conceived for the simple reason that no effective method exists of making that inquiry until it is too late to avoid the danger it represents. Indeed, for the second time in as many months, the majority continues to validate such incursions seriatim. (See *In re Rose* (2000) 22 Cal.4th 430, 466 (dis. opn. of Brown, J.).) The idea that the court can monitor legislative inroads into our jurisdiction, calling a halt to the invasion when we have determined that it has gone "too far," sacrifices the impairment of individual liberties to a kind of interbranch "comity." It is for that very practical reason the separation of powers doctrine has to operate prophylactically.

Two additional considerations fuel my concern with today's result. The majority expressly affirms the power of a reviewing court to summarily deny a disciplined

physician's writ petition – the postcard denial sent without oral argument or an opinion "in writing with reasons stated." (See Cal. Const., art. VI, § 14.) Imposing upon the Courts of Appeal the obligation to issue alternative writs as a matter of course in cases falling within Business and Professions Code section 2337 (hereafter section 2337) would go far to mitigate the unhappy potential of today's ruling. As it stands, however, today's majority expressly authorizes the Court of Appeal to dismiss summarily writ petitions falling within section 2337. (See maj. opn., *ante*, at p. 9 ["We do not agree . . . that a Court of Appeal fails to exercise its appellate jurisdiction when it summarily denies an extraordinary writ petition that lacks substantive merit or is procedurally defective."].) In my view, the summary denial of writ relief by the Court of Appeal denies a benefit the Constitution itself confers.

My concern is only compounded by looking at the alternatives available to the Legislature, alternatives that pose no risk to the constitutional powers of the judiciary and achieve the identical public end sought by section 2337. As Justice Mosk points out in his dissenting opinion, the simplest and most expeditious way to secure the ends sought by the Legislature is to declare that no court shall issue a stay of an administrative order revoking a medical license pending appellate review. (See dis. opn. of Mosk, J., *ante*, at p. 3.) Indeed, in physician misconduct cases decided under the current regime, a stay of license revocation can be issued by the Courts of Appeal only under narrowly prescribed circumstances. (See Code Civ. Proc., § 1094.5, subd. (h)(1).) Thus, in most cases, the public is fully protected against malpracticing physicians pending resolution of their appeals. The expedition

promised by section 2337 is not only unnecessary, but comes at a cost in terms of constitutional structure. Last, of course, one justifiably wonders whether the promised expedition gained by eliminating the time consumed by direct appeals of disciplined physicians seeking judicial review is really any more than the time required for meaningful judicial review in a writ proceeding, including issuance of an alternative writ, additional briefing, and oral argument. (Cf. *Lewis v. Superior Court* (1999) 19 Cal.4th 1232.) The necessary time expenditure can hardly be less than an expedited direct appeal.

Conclusion

The limits imposed by the Constitution – always permeable – now become wholly illusory. A rule that prohibits substantial impairment of the constitutional powers of the court (maj. opn., *ante*, at p. 8) is meaningless when the constitutional provisions are emptied of substantive content. The concurring opinion asserts that legislation cannot constitutionally "transform[ ] the Court of Appeal . . . into an appellate court whose jurisdiction consists entirely of writ review. . . . " (Conc. opn. of George, C.J., *ante*, at p. 1, italics omitted.) The Legislature may perhaps be forgiven if its derisive response is: "Sez who?"

BROWN, J.

IN THE COURT OF APPEAL
OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION FOUR

NELSON F. LEONE, Plaintiff and Appellant, v. MEDICAL BOARD OF CALIFORNIA, Defendant and Respondent.	B103344 (Super Ct. No. BS035371) ORDER
SHASHI D. GANTI, Plaintiff and Appellant, v. MEDICAL BOARD OF CALIFORNIA, Defendant and Respondent.	B101297 (Super. Ct. No. BS036241) (Filed Aug. 9, 2000)

THE COURT:*

These consolidated matters arise out of two factually unrelated cases. Each is an appeal taken by a doctor from a judgment entered by the superior court denying his request for administrative mandamus. (Code Civ. Proc., § 1094.5) to overturn the decision of the Medical Board of California (Board) revoking his license to practice medicine.

*VOGEL (C.S.),P.J., EPSTEIN, J., HASTINGS, J.

In each case after the doctor filed a notice of appeal, the record on appeal was prepared and lodged in this court. Ganti filed an opening brief on the merits of his appeal on December 2, 1996, but before Leone could file a brief on the merits of his appeal, Board moved to dismiss each appeal. Board relied upon then recently-enacted Business and Professions Code section 2337 (section 2337) which provides that appellate review in the Court of Appeal of a judgment of the superior court denying a doctor's request for administrative mandamus will now be done solely "pursuant to a petition for an extraordinary writ."

Because of the important issues raised by Board's motions to dismiss, we consolidated the two cases for the purpose of deciding those motions, requested and received supplemental briefing from the parties, and placed the matter on calendar for hearing. Additionally, we filed orders relieving the parties of their obligations to file briefs on the merits pending resolution of Board's motions to dismiss the appeals.

In a published opinion, we concluded section 2337 violated the provision of the California Constitution that "courts of appeal have appellate jurisdiction when superior courts have original jurisdiction. . . . " (Cal. Const., art. VI, § 11.) We therefore denied Board's motions to dismiss the two appeals. Our analysis and conclusion rendered it unnecessary to consider the doctors' contentions that section 2337 also violated due process and equal protection. Similarly, it was not necessary to address Ganti's claim that section 2337 could not apply to him because the superior court conducted its hearing in

December 1995, the month before section 2337 became effective.

The California Supreme Court granted Board's petition for review and ultimately reached a conclusion contrary to ours. In *Leone v. Medical Board* (2000) 22 Cal.4th 660, it held section 2337 did *not* violate the appellate jurisdiction clause of the California Constitution. It did not consider the due process and equal protection claims. It explained: "Because these due process and equal protection claims are outside the issues on which we granted review, and because the Court of Appeal has not yet addressed them, we decline to consider them at this time. The Court of Appeal will address these issues on remand." (*Id.* at p. 670.) The dispositional paragraph reads: "The judgment of the Court of Appeal denying [Board's] motions to dismiss is reversed, and the matter is remanded to that court for further proceedings consistent with this opinion." (*Ibid.*)

The remittitur having issued, the cases are again before us to rule upon Board's motions to dismiss the appeals. Meanwhile, the California Supreme Court has acted in a case in which it had granted review but deferred action pending its disposition in *Leone*. (See rule 29.2(c), Cal. Rules of Court.) That case is *Landau v. Superior Court*, review granted April 15, 1998, S068095. On June 14, 2000, the Supreme Court dismissed review in *Landau*, remanded the case to the Court of Appeal, and ordered the Court of Appeal opinion republished at 81 Cal.App.4th 191. *Landau* considered and rejected a doctor's contentions that section 2337 violated equal protection and due process. (*Id.* at pp. 207-212.) As noted above, the doctors in our two cases thoroughly briefed the due

process and equal protection contentions the first time we considered Board's motions to dismiss. We have reviewed those brief. Because we agree with *Landau's* analysis, there is no need for us either to receive further briefing on those issues or to set the matter for argument and decision on those points. Additionally, *Landau* rejected the doctor's claim that section 2337 could not apply to her because the administrative decision had been rendered before the January 1, 1996, effective date of section 2337. (*Id.* at pp. 213-216.) By a parity of reasoning, section 2337 applies to Ganti even though the superior court conducted its hearing in December 1995 but issued its judgment in January 1996.

In sum, there is no constitutional impediment to applying section 2337 to either of these doctors. This means their respective appeals must be dismissed and they can only seek review in this court of the superior court's judgments by petitions for extraordinary relief. Given the manner and chronology in which these cases have developed, we will exercise our discretion to construe their appeals as being timely writ petitions. (see e.g., *Olson v. Cory* (1983) 35 Cal.3d 390, 400-401.) The records necessary to decide those petitions on the merits have already been prepared and lodged with this court. Because the reason for our initial consolidation order no longer exists, we will dissolve it and set forth a briefing schedule for each matter.

The May 9, 2000, request filed by counsel that this matter be placed on calendar for further briefing and argument on Board's motions to dismiss is denied. Board's motions of July 30, 1996, and February 11, 1997, to dismiss, respectively, the appeals in B103344 and

B101297 are granted. Our order of March 5, 1997, consolidating B103344 and B101297 for purpose of ruling upon the motions to dismiss is dissolved. Our orders of October 25, 1996, and March 5, 1997, relieving the parties of their obligations to file briefs on the merits are dissolved. The notices of appeal filed in B103344 and B101297 are construed to be timely petitions for extraordinary relief. In B103344, Leone is to file within 30 days of the date of this order a petition on the merits; Board is to file a response within 30 days of the filing of that petition; and Leone may file a reply within 20 days of the filing of Board's response. In B101297, Ganti has already filed an "appellant's opening brief" on the merits which we will construe as a petition on the merits; Board is therefore ordered to file a response within 30 days of this order and Ganti may file a reply within 20 days of the filing of Board's response.

COURT OF APPEAL, FIRST APPELLATE DISTRICT
350 MCALLISTER STREET
SAN FRANCISCO, CA 94102
DIVISON 3

Alfredo Terrazas
Office Of The Attorney General
ELIHU HARRIS STATE BUILDING
1515 Clay Street, 20th Floor
Oakland, CA 94612-1413

FRANKLIN J. DAY, M.D.,

Petitioner,

v.

THE SUPERIOR COURT OF SAN FRANCISCO COUNTY,

Respondent;

DIVISION OF MEDICAL QUALITY OF THE MEDICAL BOARD OF CALIF.,

Real Party in Interest.

A080131

San Francisco County No. 982562

REMITTITUR

I, Ron D. Barrow, Clerk of the Court of Appeal of the State of California, for the First Appellate District, do hereby certify that the decision entered in the above-entitled cause on March 30, 1999 has now become final.

_ Appellant _ Respondent to recover costs
_ Each party to bear own costs
✓ Costs are not awarded in this proceeding
_ See decision for costs determination

Witness my hand and the Seal of the court affixed at my office this NOV 17 2000

[SEAL] Ron D. Barrow
Clerk of the Court
I. CALANOC
Deputy Clerk

LAW OFFICES OF

JOHN T. SCHREIBER

901 YGNACIO VALLEY ROAD
WALNUT CREEK, CALIFORNIA 94596
(925) 036-2460
FAX (925) 256-2460
E-MAIL schre09@ibm.net
CERTIFIED SPECIALIST, APPELLATE LAW
THE STATE BAR OF CALIFORNIA BOARD
OF LEGAL SPECIALIZATION

November 21, 2000

VIA FEDERAL EXPRESS

The Honorable Presiding Justice
The Honorable Associate Justices
FIRST DISTRICT, COURT OF APPEAL,
DIVISION THREE
350 McAllister Street
San Francisco, CA 94102

Re: FRANKLIN J. DAY, M.D. v. MEDICAL BOARD OF CALIFORNIA
First Appellate District, Division 3, Case No: A080131

Dear Presiding Justice McGinnis and Associate Justices Parrilli and Walker:

Pursuant to my telephone conversations with Ines, the assistant clerk in Division Three, I am formally requesting that this Court recall or stay its remittitur issued November 17, 2000. As the enclosed letter from the United States Supreme Court dated October 3, 2000 makes clear, the matter is still pending before that court. The letter states that I have sixty days from that date to revise the petition for cert and its appendix. I have been working diligently

to do so and the revised cert petition will be submitted for filing with the United States Supreme Court tomorrow, November 22, 2000. The 60-day period runs December 2. This Court will of course receive a copy of the cert petition.

Thank you for your prompt attention to this matter.

Respectfully submitted,

LAW OFFICES OF JOHN T. SCHREIBER

/s/ John T. Schreiber
JOHN T. SCHREIBER

JTS/db
Enclsure
cc: ✓ Alfredo Terrazas
Deputy Attorney General

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, DC 20543-0001

October 3, 2000

WILLIAM K. SUTER
CLERK OF THE COURT

AREA CODE 208
479-3011

John T. Schreiber
961 Ygnacio Vally [sic] Road
Walnut Creek, CA 94596

RE: Day v. San Francisco County Sup. Ct.

Dear Mr. Schreiber:

Returned are 39 copies of the petition for writ of certiorari in the above-entitled case postmarked on

September 12, 2000 and received on September 14, 2000, which fails to comply with the Rules of this Court.

The text of the petition and appendix must be typeset Roman 11-point or larger type with 2-point or more leading between lines. The typeface of footnotes must be 9-point or larger with 2-point or more leading between lines. Please note that computer generated "Roman" font is smaller than traditional Roman type and you may need to increase the font size. Rule 33.1(b).

The materials contained in the appendix have been photoreduced which is prohibited. The size of the print must comply in all respects with Rule 33.1(b).

Question(s) presented must appear on the very first page of the petition. Rule 14.1(a).

The pages containing the questions presented for review through table of authorities should be numbered (i), (ii), (iii), etc. The following pages should be numbered 1, 2, 3, etc.

Kindly correct the petition and appendix so that it complies in all respects with the Rules of the Court and return it to this office promptly so that it may be docketed. Unless the petition is received by this Office in corrected form within 60 days of the date of this letter, the petition will not be filed. Rule 14.5.

Three copies of the corrected petition must be served on opposing counsel. Rule 29.3.

This office shall retain one copy of the petition and your check in the amount of $300.00 in expectation of timely receipt of a properly prepared petition.

Enclosed are a copy of the Rules of the Court and memorandum concerning the preparation of a paid petition in booklet format.

Sincerely,
William K. Suter, Clerk
By: /s/ M. Blalock
M. Blalock
(202) 479-3023

Enclosures

STATE OF CALIFORNIA

Court of Appeal

FIRST APPELLATE DISTRICT
DIVISION THREE
350 McALLISTER STREET
SAN FRANCISCO, CA 94102-3600

[SEAL]
WILLIAM R. McGUINESS
PRESIDING JUSTICE

TELEPHONE
(415) 565-7810
FAX
(415) 565-7300

December 5, 2000

The Honorable Ronald George
Chief Justice
Supreme Court of California
350 McAllister Street
San Francisco, CA 94102-3600

Re: Request for Publication of Unpublished Opinion
Day v. Superior Court, A080131

Dear Chief Justice George:

We have received the enclosed letter requesting publication of our opinion in *Day v. Superior Court* (A080131), filed March 30, 1999 (the remittitur was not issued until November 17, 2000). A copy of the opinion is also enclosed. This court has no authority to grant the request because the decision has become final. In accordance with rule 978(a) of the California Rules of court, the request is transmitted for your consideration.

We recommend against publishing the opinion. Contrary to real party in interest's suggestion, the opinion

fails to meet the publication standard set out in rule 976(b)(1) of the California Rules of Court.

Yours truly,

/s/ William R. McGuiness
William R. McGuiness
Presiding Justice

Encls.

WRM:ss

cc: John T. Schreiber, Esq.
Alfredo Terrazas, Deputy Attorney General

10 U.S.C.A. § 1094. Licensure requirement for health-care professionals

(a)(1) A person under the jurisdiction of the Secretary of a military department may not provide health care independently as a health-care professional under this chapter unless the person has a current license to provide such care.

(2) The Secretary of Defense may waive paragraph (1) with respect to any person in unusual circumstances. The Secretary shall prescribe by regulation the circumstances under which such a waiver may be granted.

(b) The commanding officer of each health care facility of the Department of Defense shall ensure that each person who provides health care independently as a health-care professional at the facility meets the requirement of subsection (a).

(c)(1) A person (other than a person subject to chapter 47 of this title) who provides health care in violation of subsection (a) is subject to a civil money penalty of not more than $5,000.

(2) The provisions of subsections (c) and (e) through (h) of section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) shall apply to the imposition of a civil money penalty under paragraph (1) in the same manner as they apply to the imposition of a civil money penalty under that section, except that for purposes of this subsection –

(A) a reference to the Secretary in that section is deemed a reference to the Secretary of Defense; and

(B) a reference to a claimant in subsection (e) of that section is deemed a reference to the person described in paragraph (1).

(d)(1) Notwithstanding any law regarding the licensure of health-care providers, a health-care professional described in paragraph (2) may practice the health profession or professions of the health-care professional in any State, the District of Columbia, or a Commonwealth, territory, or possession of the United States, regardless of [sic] whether the practice occurs in a health care facility of the Department of Defense, a civilian facility affiliated with the Department of Defense, or any other location authorized by the Secretary of Defense.

(2) A health-care professional referred to in paragraph (1) is a member of the armed forces who –

(A) has a current license to practice medicine, osteopathic medicine, dentistry, or another health profession; and

(B) is performing authorized duties for the Department of Defense.

* * *

CALIFORNIA CONSTITUTION

ARTICLE 1 DECLARATION OF RIGHTS

SEC. 7. (a) A person may not be deprived of life, liberty, or property without due process of law or denied equal protection of the laws; provided, that nothing contained herein or elsewhere in this Constitution imposes upon the State of California or any public entity, board, or official any obligations or responsibilities which exceed those imposed by the Equal Protection Clause of the 14th Amendment to the United States Constitution with respect to the use of pupil school assignment or pupil transportation. In enforcing this subdivision or any other provision of this Constitution, no court of this State may impose upon the State of California or any public entity, board, or official any obligation or responsibility with respect to the use of pupil school assignment or pupil transportation, (1) except to remedy a specific violation by such party that would also constitute a violation of the Equal Protection Clause of the 14th Amendment to the United States Constitution, and (2) unless a federal court would be permitted under federal decisional law to impose that obligation or responsibility upon such party to remedy the specific violation of the Equal Protection Clause of the 14th Amendment of the United States Constitution.

Except as may be precluded by the Constitution of the United States, every existing judgment, decree, writ, or other order of a court of this State, whenever rendered, which includes provisions regarding pupil school assignment or pupil transportation, or which requires a plan including any such provisions shall, upon application to a

court having jurisdiction by any interested person, be modified to conform to the provisions of this subdivision as amended, as applied to the facts which exist at the time of such modification.

In all actions or proceedings arising under or seeking application of the amendments to this subdivision proposed by the Legislature at its 1979-80 Regular Session, all courts, wherein such actions or proceedings are or may hereafter be pending, shall give such actions or proceedings first precedence over all other civil actions therein.

Nothing herein shall prohibit the governing board of a school district from voluntarily continuing or commencing a school integration plan after the effective date of this subdivision as amended.

In amending this subdivision, the Legislature and people of the State of California find and declare that this amendment is necessary to serve compelling public interests, including those of making the most effective use of the limited financial resources now and prospectively available to support public education, maximizing the educational opportunities and protecting the health and safety of all public school pupils, enhancing the ability of parents to participate in the educational process, preserving harmony and tranquility in this State and its public schools, preventing the waste of scarce fuel resources, and protecting the environment.

(b) A citizen or class of citizens may not be granted privileges or immunities not granted on the same terms to all citizens. Privileges or immunities granted by the Legislature may be altered or revoked.

ARTICLE 4 LEGISLATIVE

SEC. 16. (a) All laws of a general nature have uniform operation.

* * *

ARTICLE 6 JUDICIAL

SEC. 11 (a) The Supreme Court has appellate jurisdiction when judgment of death has been pronounced. With that exception courts of appeal have appellate jurisdiction when superior courts have original jurisdiction in causes of a type within the appellate jurisdiction of the courts of appeal on June 30, 1995, and in other causes prescribed by statute. When appellate jurisdiction in civil causes is determined by the amount in controversy, the Legislature may change the appellate jurisdiction of the courts of appeal by changing the jurisdictional amount in controversy.

(b) Except as provided in subdivision (a), the appellate division of the superior court has appellate jurisdiction in causes prescribed by statute.

(c) The Legislature may permit courts exercising appellate jurisdiction to take evidence and make findings of fact when jury trial is waived or not a matter of right.

2000 CALIFORNIA RULES OF COURT

Rule 29.2. Issues on review; grant and hold

(a) [Decision on limited issues] On review of the decision of a Court of Appeal, the Supreme Court may review and decide any or all issues in the cause.

(b) [Specification of issues] After granting review of a decision of a Court of Appeal, the Supreme Court may specify the issues to be argued. Unless otherwise ordered, briefs on the merits and oral argument shall be confined to the specified issues and issues fairly included in them.

Notwithstanding its specification of issues, the Supreme Court may order argument on fewer or additional issues, or on the entire cause. The court shall give the parties reasonable notice of any specification of the issues to be argued and of any change in its specification of issues.

(c) [Grand and hold] After granting review of a decision of a Court of Appeal, the Supreme Court may order action on the cause deferred until disposition of another cause pending before the court.

Rule 977. Citation of opinions

(a) [Unpublished opinions] An opinion of a Court of Appeal or an appellate department of the superior court that is not certified for publication or ordered published shall not be cited or relied on by a court or a party in any other action or proceeding except as provided in subdivision (b).

(Subd (a) as amended effective January 1, 1997.)

(b) [Exceptions] Such an opinion may be cited or relied on:

(1) When the opinion is relevant under the doctrines of law of the case, res judicata, or collateral estoppel; or

(2) when the opinion is relevant to a criminal or disciplinary action or proceeding because it states reasons for a decision affecting the same defendant or respondent in another such action or proceeding.

(Subd (b) as amended effective January 1, 1983.)

(c) [Citation procedure] A copy of any opinion citable under subdivision (b) or of a cited opinion of any court that is available only in a computer-based source of decisional law shall be furnished to the court and all parties by attaching it to the document in which it is cited, or, if the citation is to be made orally, within a reasonable time in advance of citation.

(Subd (c) as amended effective January 1, 1997.)

(d) [Opinions ordered published by Supreme Court] An opinion of the Court of Appeal ordered published by the Supreme Court pursuant to rule 976 is citable.*

(Subd (d) adopted effective May 6, 1985.)

Rule 977 as amended effective January 1, 1997; adopted by the Supreme Court and by the Judicial Council effective January 1, 1974; previously amended effective January 1, 1983, and May 6, 1985.

*Any citation to the Court of Appeal opinion shall include reference to the grant of review and any subsequent action by the Supreme Court.

CALIFORNIA BUSINESS AND PROFESSIONS CODE

Section 801. (a) Every insurer providing professional liability insurance to a person who holds a license, certificate or similar authority from or under any agency mentioned in subdivision (a) of Section 800 (except as provided in subdivisions (b), (c), and (d)) shall send a complete report to that agency as to any settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(b) Every insurer providing professional liability insurance to a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act shall send a complete report to the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, as to any settlement over thirty thousand dollars ($30,000), or arbitration award of any amount, of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(c) Every insurer providing professional liability insurance to a person licensed pursuant to Chapter 13 (commencing with Section 4980) or Chapter 14 (commencing with Section 4990) shall send a complete report to the Board of Behavioral Science Examiners as to any settlement or arbitration award over ten thousand dollars ($10,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional services. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(d) Every insurer providing professional liability insurance to a dentist licensed pursuant to Chapter 4 (commencing with Section 1600) shall send a complete report to the Board of Dental Examiners of California as to any settlement or arbitration award over then thousand dollars ($10,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error, or omission in practice, or rendering of unauthorized professional service. The report shall be sent within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto or within 30 days after service of the arbitration award on the parties.

(e) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be

waived by both the insured and the insurer. This section shall only apply to a settlement on a policy of insurance executed or renewed on or after January 1, 1971.

Section 2000. This chapter shall be known and may be cited as the Medical Practice Act. Whenever a reference is made to the Medical Practice Act by the provisions of any statute, it is to be construed as referring to the provisions of this chapter.

Section 2305. The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state, or the revocation, suspension or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state.

Section 2337. Notwithstanding any other provision of law, superior court review of a decision revoking, suspending, or restricting a license shall take preference over all other civil actions in the matter of setting the case for hearing or trial. The hearing or trial shall be set no later

than 180 days from the filing of the action. Further continuance shall be granted only on a showing of good cause.

Notwithstanding any other provision of law, review of the superior court's decision shall be pursuant to a petition for an extraordinary writ.

Section 6082. Any person complained against and any person whose reinstatement the board may refuse to recommend may have the action of the board, or of any committee authorized by it to make a determination on its behalf, pursuant to the provisions of this chapter, reviewed by the California Supreme Court or by a California Court of Appeal in accordance with the procedure prescribed by the California Supreme Court.

Section 6083. (a) A petition to review or to reverse or modify an decision recommending the disbarment or suspension from practice of a member of the State Bar may be filed with the Supreme Court by the member within 60 days after the filing of the decision recommending such discipline.

(b) A petition to review or to reverse or modify any decision reproving a member of the State Bar, or any action enrolling him as an inactive member pursuant to Section 6007 of this code or refusing to restore him to active membership, pursuant to such section may be filed

with the Supreme Court by the member within 60 days after service upon him of notice of such decision or action.

(c) Upon such review the burden is upon the petitioner to show wherein the decision or action is erroneous or unlawful.

Section 23090. Any person affected by a final order of the board, including the department, may, within the time limit specified in this section, apply to the Supreme Court or to the court of appeal for the appellate district in which the proceeding arose, for a writ of review of such final order. The application for writ of review shall be made within 30 days after filing of the final order of the board.

Section 23090.1. The writ of review shall be made returnable at a time and place then or thereafter specified by court order and shall direct the board to certify the whole record of the department in the case to the court within the time specified. No new or additional evidence shall be introduced in such court, but the cause shall be heard on the whole record of the department as certified to by the board.

Section 23090.2. The review by the court shall not extend further than to determine, based on the whole record of the department as certified by the board, whether:

(a) The department has proceeded without or in excess of its jurisdiction.

(b) The department has proceeded in the manner required by law.

(c) The decision of the department is supported by the findings.

(d) The findings in the department's decision are supported by substantial evidence in the light of the whole record.

(e) There is relevant evidence which, in the exercise of reasonable diligence, could not have been produced or which was improperly excluded at the hearing before the department.

Nothing in this article shall permit the court to hold a trial de novo, to take evidence, or to exercise its independent judgment on the evidence.

Section 23090.3. The findings and conclusions of the department on questions of fact are conclusive and final and are not subject to review. Such questions of fact shall include ultimate facts and the findings and conclusions of the department. The board, the department, and each party to the action or proceeding before the board shall

have the right to appear in the review proceeding. Following the hearing, the court shall enter judgment either affirming or reversing the decision of the department, or the court may remand the case for further proceedings before or reconsideration by the department.

Section 23090.4. The provisions of the Code of Civil Procedure relating to writs of review shall, insofar as applicable, apply to proceedings in the courts as provided by this article. A copy of every pleading filed pursuant to this article shall be served on the board, the department, and on each party who entered an appearance before the board.

Section 23090.5. No court of this state, except the Supreme Court and the courts of appeal to the extend specified in this article, shall have jurisdiction to review, affirm, reverse, correct, or annul any order, rule, or decision of the department or to suspend, stay, or delay the operation or execution thereof, or to restrain, enjoin, or interfere with the department in the performance of its duties, but a writ of mandate shall lie from the Supreme Court or the courts of appeal in any proper case.

CALIFORNIA CODE OF CIVIL PROCEDURE

Section 1094.5. (a) Where the writ is issued for the purpose of inquiring into the validity of any final administrative order or decision made as the result of a proceeding in which by law a hearing is required to be given, evidence is required to be taken, and discretion in the determination of facts is vested in the inferior tribunal, corporation, board, or officer, the case shall be heard by the court sitting without a jury. All or part of the record of the proceedings before the inferior tribunal, corporation, board, or officer may be filed with the petition, may be filed with respondent's points and authorities, or may be ordered to be filed by the court. Except when otherwise prescribed by statute, the cost of preparing the record shall be borne by the petitioner. Where the petitioner has proceeded pursuant to Section 68511.3 of the Government Code and the Rules of Court implementing that section and where the transcript is necessary to a proper review of the administrative proceedings, the cost of preparing the transcript shall be borne by the respondent. Where the party seeking the writ has proceeded pursuant to Section 1088.5, the administrative record shall be filed as expeditiously as possible, and may be filed with the petition, or by the respondent after payment of the costs by the petitioner, where required, or as otherwise directed by the court. If the expense of preparing all or any part of the record has been borne by the prevailing party, the expense shall be taxable as costs.

(b) The inquiry in such a case shall extend to the questions whether the respondent has proceeded without, or in excess of jurisdiction; whether there was a fair trial; and whether there was any prejudicial abuse of

discretion. Abuse of discretion is established if the respondent has not proceeded in the manner required by law, the order or decision is not supported by the findings, or the findings are not supported by the evidence.

(c) Where it is claimed that the findings are not supported by the evidence, in cases in which the court is authorized by law to exercise its independent judgment on the evidence, abuse of discretion is established if the court determines that the findings are not supported by the weight of the evidence. In all other cases, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record.

(d) Notwithstanding subdivision (c), in cases arising from private hospital boards or boards of directors of districts organized pursuant to The Local Hospital District Law, Division 23 (commencing with Section 32000) of the Health and Safety Code or governing bodies of municipal hospitals formed pursuant to Article 7 (commencing with Section 37600) or article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of the Government Code, abuse of discretion is established if the court determines that the findings are not supported by substantial evidence in the light of the whole record. However, in all cases in which the petition alleges discriminatory actions prohibited by Section 1316 of the Health and Safety Code, and the plaintiff makes a preliminary showing of substantial evidence in support of that allegation, the court shall exercise its independent judgment on the evidence and abuse of discretion shall be established if the court determines that the findings are not supported by the weight of the evidence.

(e) Where the court finds that there is relevant evidence that, in the exercise of reasonable diligence, could not have been produced or that was improperly excluded at the hearing before respondent, it may enter judgment as provided in subdivision (f) remanding the case to be reconsidered in the light of that evidence; or, in cases in which the court is authorized by law to exercise its independent judgment on the evidence, the court may admit the evidence at the hearing on the writ without remanding the case.

(f) The court shall enter judgment either commanding respondent to set aside the order or decision, or denying the writ. Where the judgment commands that the order or decision be set aside, it may order the reconsideration of the case in the light of the court's opinion and judgment and may order respondent to take such further action as is specially enjoined upon it by law, but the judgment shall not limit or control in any way the discretion legally vested in the respondent.

(g) Except as provided in subdivision (h), the court in which proceedings under this section are instituted may stay the operation of the administrative order or decision pending the judgment of the court, or until the filing of a notice of appeal from the judgment or until the expiration of the time for filing the notice, whichever occurs first. However, no such stay shall be imposed or continued if the court is satisfied that it is against the public interest. The application for the stay shall be accompanied by proof of service of a copy of the application on the respondent. Service shall be made in the manner provided by Title 5 (commencing with Section 405) of Part 2 or Chapter 5 (commencing with Section

1010) of Title 14 of Part 2. If an appeal is taken from a denial of the writ, the order or decision of the agency shall not be stayed except upon the order of the court to which the appeal is taken. However, in cases where a stay is in effect at the time of filing the notice of appeal, the stay shall be continued by operation of law for a period of 20 days from the filing of the notice. If an appeal is taken from the granting of the writ, the order or decision of the agency is stayed pending the determination of the appeal unless the court to which the appeal is taken shall otherwise order. Where any final administrative order or decision is the subject of proceedings under this section, if the petition shall have been filed while the penalty imposed is in full force and effect, the determination shall not be considered to have become moot in cases where the penalty imposed by the administrative agency has been completed or complied with during the pendency of the proceedings.

(h) (1) The court in which proceedings under this section are instituted may stay the operation of the administrative order or decision of any licensed hospital or any state agency made after a hearing required by statute to be conducted under the Administrative Procedure Act, as set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, conducted by the agency itself or in administrative law judge on the staff of the Office of Administrative Hearings pending the judgment of the court, or until the filing of a notice of appeal from the judgment or until the expiration of the time for filing the notice, whichever occurs first. However, the stay shall not be imposed or continued unless the court is satisfied that

the public interest will not suffer and that the licensed hospital or agency is unlikely to prevail ultimately on the merits. The application for the stay shall be accompanied by proof of service of a copy of the application on the respondent. Service shall be made in the manner provided by Title 5 (commencing with Section 405) of Part 2 or Chapter 5 (commencing with Section 1010) of Title 14 of Part 2.

(2) The standard set forth in this subdivision for obtaining a stay shall apply to any administrative order or decision of an agency that issues licenses pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code or pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act. With respect to orders or decisions of other state agencies, the standard in this subdivision shall apply only when the agency has adopted the proposed decision of the administrative law judge in its entirety or has adopted the proposed decision but reduced the proposed penalty pursuant to subdivision (b) of Section 11517 of the Government Code; otherwise the standard in subdivision (g) shall apply.

(3) If an appeal is taken from a denial of the writ, the order or decision of the hospital or agency shall not be stayed except upon the order of the court to which the appeal is taken. However, in cases where a stay is in effect at the time of filing the notice of appeal, the stay shall be continued by operation of law for a period of 20 days from the filing of the notice. If an appeal is taken from the granting of the writ, the order or decision of the hospital or agency is stayed pending the determination of the appeal unless the court to which the appeal is taken

shall otherwise order. Where any final administrative order or decision is the subject of proceedings under this section, if the petition shall have been filed while the penalty imposed is in full force and effect, the determination shall not be considered to have become moot in cases where the penalty imposed by the administrative agency has been completed or complied with during the pendency of the proceedings.

(i) Any administrative record received for filing by the clerk of the court may be disposed of as provided in Sections 1952, 1952.2, and 1952.3.

(j) Effective January 1, 1996, this subdivision shall apply to state employees in State Bargaining Unit 5. This subdivision shall apply to state employees in State Bargaining Unit 8. For purposes of this section, the court is not authorized to review any disciplinary decisions reached pursuant to Section 19576.1 or 19576.5 of the Government Code.

(k) This section shall not apply to state employees in State Bargaining Unit 11 disciplined or rejected on probation for positive drug test results who expressly waive appeal to the State Personnel Board and invoke arbitration proceedings pursuant to a State Bargaining Unit 11 collective bargaining agreement.

CALIFORNIA GOVERNMENT CODE

Section 3520. (a) Judicial review of a unit determination shall only be allowed: (1) when the board, in response to a petition from the state or an employee organization, agrees that the case is one of special importance and joins in the request for such review; or (2) when the issue is raised as a defense to an unfair practice complaint. The board order directing an election shall not be stayed pending judicial review.

Upon receipt of a board order joining in the request for judicial review, a party to the case may petition for a writ of extraordinary relief from the unit determination decision or order.

(b) Any charging party, respondent, or intervenor aggrieved by a final decision or order of the board in an unfair practice case, except a decision of the board not to issue a complaint in such a case, may petition for a writ of extraordinary relief from such decision or order.

(c) Such petition shall be filed in the district court of appeal in the appellate district where the unit determination or unfair practice dispute occurred. The petition shall be filed within 30 days after issuance of the board's final order, order denying reconsideration, or order joining in the request for judicial review, as applicable. Upon the filing of such petition, the court shall cause notice to be served upon the board and thereupon shall have jurisdiction of the proceeding. The board shall file in the court the record of the proceeding, certified by the board, within 10 days after the clerk's notice unless such time is extended by the court for good cause shown. The court

shall have jurisdiction to grant to the board such temporary relief or restraining order it deems just and proper and in like manner to make and enter a decree enforcing, modifying, or setting aside the order of the board. The findings of the board with respect to questions of fact, including ultimate facts, if supported by substantial evidence on the record considered as a whole, shall be conclusive. The provisions of Title 1 (commencing with Section 1067) of Part 3 of the Code of Civil Procedure relating to writs shall, except where specifically superseded herein, apply to proceedings pursuant to this section.

(d) If the time to petition for extraordinary relief from a board decision has expired, the board may seek enforcement of any final decision or order in a district court of appeal or a superior court in the district where the unit determination or unfair practice case occurred. If, after hearing, the court determines that the order was issued pursuant to procedures established by the board and that the person or entity refuses to comply with the order, the court shall enforce such order by writ of mandamus. The court shall not review the merits of the order.

Section 3542. (a) No employer or employee organization shall have the right to judicial review of a unit determination except: (1) when the board in response to a petition from an employer or employee organization, agrees that the case is one of special importance and joins in the request for such review; or (2) when the issue is raised as a defense to an unfair practice complaint. A

board order directing an election shall not be stayed pending judicial review.

Upon receipt of a board order joining in the request for judicial review, a party to the case may petition for a writ of extraordinary relief from the unit determination decision or order.

(b) Any charging party, respondent, or intervenor aggrieved by a final decision or order of the board in an unfair practice case, except a decision of the board not to issue a complaint in such a case, may petition for a writ of extraordinary relief from such decision or order.

(c) Such petition shall be filed in the district court of appeal in the appellate district where the unit determination or unfair practice dispute occurred. The petition shall be filed within 30 days after issuance of the board's final order, order denying reconsideration, or order joining in the request for judicial review, as applicable. Upon the filing of such petition, the court shall cause notice to be served upon the board and thereupon shall have jurisdiction of the proceeding. The board shall file in the court the record of the proceeding, certified by the board within 10 days after the clerk's notice unless such time is extended by the court for good cause shown. The court shall have jurisdiction to grant to the board such temporary relief or restraining order it deems just and proper and in like manner to make and enter a decree enforcing, modifying, or setting aside the order of the board. The findings of the board with respect to questions of fact, including ultimate facts, if supported by substantial evidence on the record considered as a whole, are conclusive. The provisions of Title 1 (commencing with section

1067) of Part 3 of the Code of Civil Procedure relating to writs shall, except where specifically superseded herein, apply to proceedings pursuant to this section.

(d) If the time to petition for extraordinary relief from a board decision has expired, the board may seek enforcement of any final decision or order in a district court of appeal or a superior court in the district where the unit determination or unfair practice case occurred. The board shall respond within 10 days to any inquiry from a party to the action as to why the board has not sought court enforcement of the final decision or order. If the response does not indicate that there has been compliance with the board's final decision or order, the board shall seek enforcement of the final decision or order upon the request of the party. The board shall file in the court the record of the proceeding, certified by the board, and appropriate evidence disclosing the failure to comply with the decision or order. If, after hearing, the court determines that the order was issued pursuant to procedures established by the board and that the person or entity refuses to comply with the order, the court shall enforce such order by writ of mandamus. The court shall not review the merits of the order.

Section 3564. (a) No employer or employee organization shall have the right to judicial review of a unit determination except: (1) when the board in response to a petition from an employer or employee organization, agrees that the case is one of special importance and joins in the request for such review; or (2) when the issue is

raised as a defense to an unfair practice complaint. A board order directing an election shall not be stayed pending judicial review.

Upon receipt of a board order joining in the request for judicial review, a party to the case may petition for a writ of extraordinary relief from the unit determination decision or order.

(b) Any charging party, respondent, or intervenor aggrieved by a final decision or order of the board in an unfair practice case, except a decision of the board not to issue a complaint in such a case, may petition for a writ of extraordinary relief from such decision or order.

(c) Such petition shall be filed in the district court of appeal in the appellate district where the unit determination or unfair practice dispute occurred. The petition shall be filed within 30 days after issuance of the board's final order, order denying reconsideration, or order joining in the request for judicial review, as applicable. Upon the filing of such petition, the court shall cause notice to be served upon the board and thereupon shall have jurisdiction of the proceeding. The board shall file in the court the record of the proceeding, certified by the board, within 10 days after the clerk's notice unless such time is extended by the court for good cause shown. The court shall have jurisdiction to grant to the board such temporary relief or restraining order it deems just and proper and in like manner to make and enter a decree enforcing, modifying, or setting aside the order of the board. The findings of the board with respect to questions of fact,

including ultimate facts, if supported by substantial evidence on the record considered as a whole, are conclusive. The provisions of Title 1 (commencing with Section 1067) of Part 3 of the Code of Civil Procedure relating to writs shall, except where specifically superseded herein, apply to proceedings pursuant to this section.

(d) If the time to petition for extraordinary relief from a board decision has expired, the board may seek enforcement of any final decision or order in a district court of appeal or a superior court in the district where the unit determination or unfair practice case occurred. If, after hearing, the court determines that the order was issued pursuant to procedures established by the board and that the person or entity refuses to comply with the order, the court shall enforce such order by writ of mandamus. The court shall not review the merits of the order.

Section 11500. In this chapter unless the context or subject matter otherwise requires:

(a) "Agency" includes the state boards, commissions, and officers to which this chapter is made applicable by law, except that wherever the word "agency" alone is used the power to act may be delegated by the agency, and wherever the words "agency itself" are used the power to act shall not be delegated unless the statutes relating to the particular agency authorize the delegation of the agency's power to hear and decide.

(b) "Party" includes the agency, the respondent, and any person, other than an officer or an employee of

the agency in his or her official capacity, who has been allowed to appear or participate in the proceeding.

(c) "Respondent" means any person against whom an accusation is filed pursuant to Section 11503 or against whom a statement of issues is filed pursuant to Section 11504.

(d) "Administrative law judge" means an individual qualified under Section 11502.

(e) "Agency member" means any person who is a member of any agency to which this chapter is applicable and includes any person who himself or herself constitutes an agency.

Section 11503. A hearing to determine whether a right, authority, license or privilege should be revoked, suspended, limited or conditioned shall be initiated by filing an accusation. The accusation shall be a written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his defense. It shall specify the statutes and rules which the respondent is alleged to have violated, but shall not consist merely of charges phrased in the language of such statutes and rules. The accusation shall be verified unless made by a public officer acting in his official capacity or by an employee of the agency before which the proceeding is to be held. The verification may be on information and belief.

Section 11511. On verified petition of any party, an administrative law judge or, if an administrative law judge has not been appointed, an agency may order that the testimony of any material witness residing within or without the state be taken by deposition in the manner prescribed by law for depositions in civil actions under Article 3 (commencing with Section 2016) of Chapter 3 of Title 4 of Part 4 of the **Code** of Civil Procedure. The petition shall set forth the nature of the pending proceeding; the name and address of the witness whose testimony is desired; a showing of the materiality of the testimony; a showing that the witness will be unable or cannot be compelled to attend; and shall request an order requiring the witness to appear and testify before an officer named in the petition for that purpose.

The petitioner shall serve notice of hearing and a copy of the petition on the other parties at least 10 days before the hearing. Where the witness resides outside the state and where the administrative law judge or agency has ordered the taking of the testimony by deposition, the agency shall obtain an order of court to that effect by filing a petition therefor in the superior court in Sacramento County. The proceedings thereon shall be in accordance with the provisions of Section 11189.

CALIFORNIA LABOR CODE

Section 1160.8. Any person aggrieved by the final order of the board granting or denying in whole or in part the relief sought may obtain a review of such order in the court of appeal having jurisdiction over the county wherein the unfair labor practice in question was alleged to have been engaged in, or wherein such person resides or transacts business, by filing in such court a written petition requesting that the order of the board be modified or set aside. Such petition shall be filed with the court within 30 days from the date of the issuance of the board's order. Upon the filing of such petition, the court shall cause notice to be served upon the board and thereupon shall have jurisdiction of the proceeding. The board shall file in the court the record of the proceeding, certified by the board within 10 days after the clerk's notice unless such time is extended by the court for good cause shown. The court shall have jurisdiction to grant to the board such temporary relief or restraining order it deems just and proper and in like manner to make and enter a decree enforcing, modifying and enforcing as so modified, or setting aside in whole or in part, the order of the board. The findings of the board with respect to questions of fact if supported by substantial evidence on the record considered as a whole shall in like manner be conclusive.

An order directing an election shall not be stayed pending review but such order may be reviewed as provided in Section 1158.

If the time for review of the board order as lapsed, and the person has not voluntarily complied with the board's order, the board may apply to the superior court

in any county in which the unfair labor practice occurred or wherein such person resides or transacts business or enforcement of its order. If after hearing, the court determines that the order was issued pursuant to the procedures established by the board and that the person refuses to comply with the order, the court shall enforce such order by writ of injunction or other proper process. The court shall not review the merits of the order.

Section 5950. Any person affected by an order, decision, or award of the appeals board may, within the time limit specified in this section, apply to the Supreme Court or to the court of appeal for the appellate district in which he resides, for a writ of review, for the purpose of inquiring in to and determining the lawfullness of the original order, decision, or award or of the order, decision, or award following reconsideration. The application for writ of review must be made within 45 days after a petition for reconsideration is denied, or, if a petition is granted or reconsideration is had on the appeal board's own motion, within 45 days after the filing of the order, decision, or award following reconsideration.

Section 5951. The writ of review shall be made returnable at a time and place then or thereafter specified by court order and shall direct the appeals board to certify its record in the case to the court within the time therein

specified. No new or additional evidence shall be introduced in such court, but the cause shall be heard on the record of the appeals board, as certified to by it.

Section 5952. The review by the court shall not be extended further than to determine, based upon the entire record which shall be certified by the appeals board, whether:

(a) The appeals board acted without or in excess of its powers.

(b) the order, decision, or award was procured by fraud.

(c) The order, decision, or award was unreasonable.

(d) The order, decision, or award was not supported by substantial evidence.

(e) If findings of fact are made, such findings of fact support the order, decision, or award under review.

Nothing in this section shall permit the court to hold a trial de novo, to take evidence, or to exercise its independent judgment on the evidence.

Section 5953. The findings and conclusions of the appeals board on questions of fact are conclusive and final and are not subject to review. Such questions of fact

shall include ultimate facts and the findings and conclusions of the appeals board. The appeals board and each party to the action or proceeding before the appeals board shall have the right to appear in the review proceeding. Upon the hearing, the court shall enter judgment either affirming or annulling the order, decision, or award, or the court may remand the case for further proceedings before the appeals board.

Section 5954. The provisions of the Code of Civil Procedure relating to writs of review shall, so far as applicable, apply to proceedings in the court under the provisions of this article. A copy of every pleading filed pursuant to the terms of this article shall be served on the appeals board and upon every party who entered an appearance in the action before the appeals board and whose interest therein is adverse to the party filing such pleading.

Section 5955. No court of this state, except the Supreme Court and the courts of appeal to the extent herein specified, has jurisdiction to review, reverse, correct, or annul any order, rule, decision, or award of the appeals board, or to suspend or delay the operation or execution thereof, or to restrain, enjoin, or interfere with the appeals board in the performance of its duties but a writ of mandate shall lie from the Supreme Court or a court of appeal in all proper cases.

CALIFORNIA PUBLIC UTILITIES CODE

Section 1756. (a) Within 30 days after the commission issues its decision denying the application for a rehearing, or, if the application was granted, then within 30 days after the commission issues its decision on rehearing, or at least 120 days after the application is granted if no decision on rehearing has been issued, any aggrieved party may petition for a writ of review in the court of appeal or the Supreme Court for the purpose of having the lawfulness of the original order or decision or of the order or decision on rehearing inquired into and determined. If the writ issues, it shall be made returnable at a time and place specified by court order and shall direct the commission to certify its record in the case to the court within the time specified.

(b) The petition for review shall be served upon the executive director of the commission either personally or by service at the office of the commission.

(c) For purposes of this section, the issuance of a decision or the granting of an application shall be construed to have occurred on the date when the commission mails the decision or grant to the parties to the action or proceeding.

(d) The venue of a petition filed in the court of appeal pursuant to this section shall be in the judicial district in which the petitioner resides. If the petitioner is a business, venue shall be in the judicial district in which the petitioner has its principal place of business in California.

(e) Any party may seek from the Supreme Court, pursuant to California Rules of Court, an order transferring related actions to a single appellate district.

(f) For purposes of this section, review of decisions pertaining solely to water corporations shall only be by petition for writ of review in the Supreme Court, except that review of complaint or enforcement proceedings may be in the court of appeal or the Supreme Court.

(g) No order or decision arising out of a commission proceeding under Section 854 shall be reviewable in the court of appeal pursuant to subdivision (a) if the application for commission authority to complete the merger or acquisition was filed on or before December 31, 1998, by two telecommunications-related corporations including at least one which provides local telecommunications service to over one million California customers. These orders or decisions shall be reviewed pursuant to the Public Utilities Code in existence on December 31, 1998.

(h) This section shall remain in effect only until January 1, 2001, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2001, deletes or extends that date.

Section 1759. (a) No court of this state, except the Supreme Court and the court of appeal, to the extent specified in this article, shall have jurisdiction to review, reverse, correct, or annul any order or decision of the

commission or to suspend or delay the execution or operation thereof, or to enjoin, restrain, or interfere with the commission in the performance of its official duties, as provided by law and the rules of court.

(b) The writ of mandamus shall lie from the Supreme Court and from the court of appeal to the commission in all proper cases as prescribed in Section 1085 of the Code of Civil Procedure.